WELCOME!

TODAY'S DATE: _____

About You

Name:		Nickname:
Birthdate: / /	Age:	SS#:
Email address:		
Street address:		Apt. #
City:	State:	Zip:
Cell phone:	Home phone:	Work phone:

(If your phone number is disconnected and we are unable to contact you with another phone number, your appointment will be cancelled.)

Employer:	Drivers License:	St.:
Emergency Contact:	Relationship:	Phone Number:
How did you hear about us? Pt. Name:		☐ Website
☐ Radio Which station?	☐ Other source:	

Medical Insurance

Do you have medical insurance? Yes No		
Insurance company name:		
Member employer:		
Member:	Birthdate: / /	Ss#
Member street address:		Apt. #
City:	State:	Zip:
Member ID#	Group ID#	

Dental Insurance

Do you have dental insurance? Yes No		
Insurance company name:		
Member employer:		
Member:	Birthdate: / /	SS#
Member street address:		Apt. #
City:	State:	Zip:
Member id#	Group id#	

Secondary Dental Insurance

Do you have a secondary dental insurance plan? Yes No		
Insurance company name:		
Member employer:		
Member:	Birthdate: / /	Ss#
Member street address:		Apt. #
City:	State:	ZIP:
Member ID#	Group ID#	

Medical History

Physicians Name:	Phone:	Date of Last visit:
Are you currently under Your physicians care?		

Your current physical health is:	☐ Good	☐ Fair	☐ Poor
Are you taking any blood thinners such as **Coumadin, warfarin, plavix or aspirin daily?**		Yes	No
Are you taking any **prescription/over the counter, vitamins or herbal supplement drugs?**		Yes	No
Please list each one:			
Do you smoke or use tobacco in any other form?		Yes	No
Have you ever taken Phen-Phen? (Also known as Redux or Pondimin)		Yes When:	No
For Women:			
Are you taking birth control pills?		Yes	No
Are you pregnant?		Yes Week #:	No
Are you nursing?		Yes	No

Are You Allergic To Any Of The Following?

Aspirin	Yes	No	Acrylic	Yes	No	Clindamycin	Yes	No
Codeine	Yes	No	Dental Anesthetic	Yes	No	Latex	Yes	No
Morphine	Yes	No	Penicillin	Yes	No	Tetracycline	Yes	No
Erythromycin	Yes	No	Other:					

Have You Ever Had The Following Diseases Or Medical Conditions?

Please check Yes or No.

Yes	No		Yes	No		Yes	No	
		AIDS or HIV Positive			Emphysema			Low Blood Pressure
		Abnormal Bleeding			Epilepsy			Mitral Valve Prolapse
		Alcohol / Drug Abuse			Fainting Spells			Pacemaker
		Anemia			Frequent Headaches			Psychiatric Problems
		Angina / Chest Pain			Glaucoma			Renal Dialysis
		Arthritis			Hay Fever			Rheumatic / Scarlet Fever
		Artificial Bone / Joints / Valve			Heart Attack / Failure			Seizures
		Asthma			Heart Murmur			Shingles
		Bacterial Endocarditis			Heart Disease / Surgery			Sickle Cell Disease / Traits
		Blood Transfusions			Hemophilia			Sinus Problems
		Cancer: _____			Hepatitis			Stroke
		Chemotherapy			Herpes / Fever Blisters			Thyroid Problems
		Colitis			High Blood Pressure			Radiation Treatment
		Congenital Heart Defect			Hospitalized any Reason			Tuberculosis
		Diabetes			Kidney Problems			Ulcers
		Difficulty Breathing			Liver Disease			Venereal Disease

Today's Visit

Reason for today's visit:

Do you require antibiotics before dental treatment? Yes No	Did you take it today? Yes No
Are you currently in pain? Yes No	Your current dental health is: Good Fair Poor
Do you now or have you ever experienced jaw discomfort TMJ/TMD? Yes No	
Do your gums ever bleed? Yes No	Have you ever had a gum treatment? Yes No
Are your teeth sensitive to hot, cold or anything else? Hot Cold Other:	
Have you lost any teeth? If so, why?	Do you like your smile? Yes No
Have you ever had a serious or previous problem with dental work? Yes No	
Previous dentist:	Last visit date:
How many times a week do you floss?	How many times a day do you brush?
Type of bristles? Soft Medium Hard	How often do you replace your toothbrush?

Assignment and Release

To the best of my knowledge all preceding answers are correct. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorize the dental staff and doctor to administer such medicines and perform any necessary diagnostic and therapeutic procedures as may be necessary for proper dental care with my informed consent. I also consent to the use of periodic appointment reminder phone calls and appointment reminder items via mail.

I understand that my dental insurance is a contract between me and the insurance carrier and not between the insurance carrier, and the dentist. Therefore, I am still responsible for all dental fees, rendered on my behalf or my dependents whether or not paid by my insurance

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors /health practitioners.

I authorize and request my insurance company to pay directly to the dentist, benefits otherwise payable to me.

I understand that I will be charged for all dental treatment and that my dental insurance carrier may pay less than the actual bill for services. I am responsible to pay any co-payments, deductibles, or unpaid balances from my insurance. I understand, that waiving or forgiving such co-payments or deductibles is unethical and illegal.

Patient Signature (Parent or Guardian)	Date

Is there another individual you would like to release medical records, financial information and treatment plans to?

Name:	Relationship to patient:
Name:	Relationship to patient: