WELCOME

Welcome to our office. We appreciate the confidence you place with us to provide you with quality dental care. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If you have any questions, don't hesitate to ask.

ABOUT YOU

Today's Date: ____/_____/_____ E-Mail Address: ________________________

Name: _________________________ Preferred Name: _____________ Sex: Male or Female

Date of Birth: _____/______/_______ Age: ________ SS#: ______-_______-_________

Mailing Address: ____

Street City State Zip

Home Phone: (___)_________ Work Phone: (___)___________ Cell Phone: (___)____________

Referred By (circle one): Drive-By Yellow Pages Radio Internet Family/Friend Who? _________________

Employer: ____________________________________

Employers Address: ____

Street City State Zip

Status (circle one): Minor Single Married Spouses Name: _________________________

Do you have children? Y or N How Many? ______

Name(s) of person(s) we may discuss your account or treatment with: __________________

____

ACCOUNT INFO

Person ultimately responsible for this account:

Name: ______________________________ Relation: ______________________

Billing Address: ____

Street City State Zip

SS#: ____-_____-______ Phone: (___)_______________

____ Initials I hereby authorize assignment of my insurance right and benefits directly to the provider for services rendered. **I fully understand I am solely responsible for any balance not paid by my insurance company within 60 days (if offered at this office).**

INSURANCE INFO

Primary Dental Insurance Co. Name: __________________________________

Address:____

Street City State Zip

Phone:(___)____________ Member ID #: ___________________ Group #: _________________

Insureds Name: ______________________________________ Relation: _______________

Insureds Date of Birth: ____/____/______

**We do not file secondary insurances. However, if you have secondary coverage we will be more than happy to give you the necessary documentation so you can be directly reimbursed.

Medical History

Please list **ALL** medications you are currently taking, and include strength and dosage:

___

___

Do you have or have you had any of the following diseases, medical condition or procedure? Please Circle Y/N

Y N Heart Attack/Stroke	**Y N** Cancer/Tumors	**Y N** Cosmetic Surg.
Y N Heart Surg./Pacemaker	**Y N** Kidney Problem	**Y N** Radiation/Cobalt Treatment
Y N Heart Murmur	**Y N** Liver Problem	**Y N** Hepatitis
Y N Rheumatic Fever	**Y N** Respiratory Problem	**Y N** HIV/AIDS/ARC
Y N Mitral Valve Prolapse	**Y N** Sinus Problem	**Y N** Arthritis/Rheumatism
Y N Artificial Valve	**Y N** Stomach Problem/Ulcer	**Y N** Artificial Bones/Joints
Y N Heart Disease	**Y N** Psychiatric Problem	**Y N** Emphysema
Y N Congenital Heart Defect	**Y N** Venereal Disease	**Y N** Fainting/Seizures/Epilepsy
Y N Chest Pains	**Y N** Alcohol/Drug Abuse	**Y N** Severe/Frequent Headaches
Y N Scarlet Fever	**Y N** TB	**Y N** Chemotherapy Treatment
Y N Frequent Neck Pain	**Y N** Nervousness	**Y N** Asthma
Y N Jaw Problem/TMD	**Y N** Thyroid Problem	**Y N** Difficulty Breathing
Y N Back Problems	**Y N** Shingles	**Y N** Diabetes/Hypoglycemia
Y N Leukemia	**Y N** High/Low Blood Pressure	**Y N** Anemia
Y N Bleeding Problems	**Y N** Glaucoma	

Please list all other surgeries or medical condition you have or have had: ______________________

___

Are you allergic to any of the following: Latex Penicillin/Amoxicillin Tetracycline Aspirin

Foods: ____________________________ Other: _____________________________________

Do you use tobacco? **Y** or **N** How used? ____________ How Much? ________ How Long? ______

Please rate your health from 1-10: _______ Do you wear contact lenses? **Y** or **N**

Have you ever taken the drug Phen-fen or Redux? **Y** or **N**

Have you taken or are you taking a bone strengthening medication called bisphosphonate? **Y or N**

If yes, what type? Boniva Reclast Fosamax Other:_______________________

For Women: Are you taking any form of Contraceptives? **Y** or **N**

If yes, what type? _______________________ How many children have you had? ________

Are you pregnant? **Y** or **N** If yes, how long: ___________ Are you nursing? **Y** or **N**

Dental History

Reason for Visit (circle one): Exam Emergency Consultation

Are you in pain? **Y** or **N** How long? _________

Please circle any of the following that apply to you:

Discomfort, clicking or popping in jaw	Lost/Broken Filling(s)	Stained teeth
Red, swollen or bleeding gums	Teeth grinding	Locking jaw
Sensitive tooth, teeth or gums	Ringing in ears	Bad breath
Blisters/Sores in or around the mouth	Broken/chipped teeth	

Do you require pre-medication? **Y** **N** or **Don't Know**

Previous Dentist: _________________________________ Phone: (___)_________________

Last Dental exam : _____/______/______ Last Dental Xrays: _____/_____/_____

Times a day you brush? ______ Times a day you floss? ______

Type of toothbrush you use? Soft Med Hard Electric Are you happy with your smile? Y or N

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*I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

* I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform the office of any changes to the information I have provided.

Signature: ____________________________________ Date: _____/______/_______

Adult Patient Parent/Guardian Spouse