A CARING DENTAL GROUP

PATIENT INFORMATION

FIRST: _____ MIDDLE: _____ LAST: _____ Jr/Sr:_____

PREFERRED NAME: _____

IF CHILD, PARENT'S NAME: _____ MIDDLE: _____ LAST: _____

STREET: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK (IF ABLE TO CONTACT): _____

CELL PHONE: _____ EMAIL: _____

PATIENT SOCIAL SECURITY NUMBER: _____-_____-_____ PATIENT D.O.B: _____/_____/_____

EMERGENCY CONTACT: _____ PHONE: _____

HOW DID YOU HEAR ABOUT US? ☐ FLYER ☐ VALPAK ☐ GOLD CLIPPER ☐ POSTCARD

☐ GOOGLE ☐ OUR WEBSITE ☐ REFERRED BY: _____
(PERSON'S NAME)

OTHER FAMILY MEMBERS IN PRACTICE: _____

INSURANCE INFORMATION

DO YOU HAVE DENTAL INSURANCE? (circle) **YES** **NO**

	PRIMARY INSURANCE
Subscriber Name	
Subscriber SSN	
Date of Birth	
Relationship to Subscriber	☐SELF ☐SPOUSE ☐CHILD OTHER_____
Employer Name	
Employer Phone	
Insurance Company	
Insurance Group #	
Insurance Phone #	

RELEASE

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) heath care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another Dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

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I attest to the accuracy of the information on this page.

PATIENTS OR GUARDIANS SIGNATURE _____ **DATE** _____

PATIENT'S NAME:_____ **DOB**: ____/____/_____

ARE YOU UNDER THE CARE OF A PHYSICIAN? (circle) **YES NO** LAST PHYSICAL DATE:_____

PHYSICIAN'S NAME:_____ADDRESS OR PHONE #: _____

DATE OF LAST DENTAL VISIT:_____ WHAT WAS DONE AT THAT TIME?_____

PREVIOUS DENTIST NAME & ADDRESS: _____ DATE OF LAST CLEANING:___/___/_____

HAVE YOU TAKEN ANTIBIOTICS PRIOR TO DENTAL TREATMENT PROCEDURES IN THE PAST? (CIRCLE) **YES NO**

HAVE YOU HAD ANY PROBLEMS WITH ANTIBIOTICS (PENICILLIN, ETC…), ANESTHETICS, ANY MEDICATIONS, METALS OR LATEX? (CIRCLE) **YES NO**

ARE YOU CURRENTLY PREGNANT? **YES NO**

CURRENTLY TAKING BIRTH CONTROL? **YES NO**

List any medications you are allergic to:

1._____ 2. _____ 3. _____

List any medications you are taking (including non-prescription drugs and birth control):

1. _____ 2. _____ 3._____

DENTAL HISTORY

Do you have any history of:	Y	N		Y	N		Y	N
Have you made regular visits? How Often?			Do you have frequent headaches, neck aches, or shoulder aches?			Have you had any orthodontic work?		
Were Dental X-Rays taken?			Does food get caught in your teeth?			Are any of your teeth loose, tipped, shifted, or chipped?		
Have you lost any teeth or have they been removed?			Are you sensitive to: Hot? Cold? Sweet? Pressure?			Do you want whiter/straighter teeth?		
Have they been replaced? Perm Bridge ____ Age _____ Removable_____ Age _____ Dentures_____ Age_____ Implants _____Age _____			Have you ever had gum treatment or surgery? A. What?_____ B. Where?_____ C. When?_____			Have you ever had any unpleasant dental experiences in the past? If so, explain:		
Are you happy with the replacement?			Do your gums bleed or hurt?			How often do you brush? _____		
Would you like to know more about permanent replacements?			Does your jaw click or pop?			Do you floss? How Often?		
Have you ever had any complications or problem with previous replacements?			Do you clench or grind teeth?			COMMENTS OR CONCERNS:		

MEDICAL HISTORY

Do you have a history of:	Y	N		Y	N		Y	N		Y	N
Heart Problem			Breathing Problems			Psychiatric Treatment			Thyroid Disease		
Heart Murmur			Lung Disease			Stroke			Liver Disease		
Mitral Valve Prolapse			Tuberculosis			Epilepsy or seizures			Hepatitis (A B C)		
Artificial Heart Valve			Asthma/COPD			Fainting or Dizzy Spells			Kidney Disease		
Pace Maker			Sinus Problems			Ulcers or stomach problems			Dialysis		
High/Low Blood Pressure			Blood Disorder			Arthritis/Osteoporosis			Cancer:		
Rheumatic Fever			Anemia/Leukemia			IV medication for osteoporosis			Chemotherapy		
Aspirin			Excessive Bleeding			Venereal Disease			Radiation Treatment		
Blood Thinners			Blood Transfusion			HIV / AIDS If yes, are you in treatment?			Use of Tobacco		
Artificial Joints/Prosthesis If yes, when was it placed? What joint? _____			Vision Impaired						Drug Addiction		
			Hearing Impaired			Diabetes Type I/ Type II			Consume Alcoholic Beverages		
OTHER MEDICAL CONDITIONS OR CONCERNS:						Major Surgeries: A. What?_____ B. Where?_____ C. When?_____			Allergies or Hives (please list)		

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge.

PATIENT'S SIGNATURE: _____DATE: _____

DR'S SIGNATURE: _____DATE: _____