In order to begin treatment, the following information is necessary. Please complete fully and print legibly. All information, of course, will be held in strict confidence. Thank you for joining our practice.

## PATIENT INFORMATION

SS#:_____-_____-_____

Name_____DL#_____DOB____/____/____Age___

Home Address_____City_____Zip_____

Home # (_____)_____-_____Work # (_____)_____-_____Cell # (_____)_____-_____

Marital Status_____Employer_____Occupation_____

Whom may we thank for referring you?_____ E-mail_____

Dental appointment reminder/statements by **Email:** Yes No **Text:** Yes No

## INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Company:_____Phone # (_____)_____-_____

Name of Insured:_____SS# / ID#_____DOB____/____/____

Relationship to Patient_____Employer _____Group #_____

SECONDARY INSURANCE

Insurance Company:_____Phone # (_____)_____-_____

Name of Insured:_____SS# / ID#_____DOB____/____/____

Relationship to Patient_____Employer _____Group #_____

## IN CASE OF AN EMERGENCY

Please provide the following for a friend or relative not living with you.

Name_____Relationship to you_____

Home # (_____)_____-_____Work # (_____)_____-_____Cell # (_____)_____-_____

This is to certify that I, the undersigned, consent to the performing of whatever dental services and/or surgical procedures may be decided upon to be necessary or advisable, and to the use of local or general anesthetic as may be deemed advisable by the dentist. I hereby authorize my dentist to release and all medical information to the above-named insurance carrier(s) for the purpose of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effect from the date of signing until revoked in writing.

I hereby authorize my insurance carrier to pay directly to the within named dentist(s) the dental benefits otherwise payable to me. As most insurance plans only a portion of the treatment, any portion NOT PAID or NOT COVERED by the insurance company is DUE and PAYABLE at the time of treatment unless other arrangements have been made.

**We require 48 hour's notice for cancellations. We do impose a fee of $50 per hour for late notice cancellations/missed appointments**

_____PATIENT_____DATE_____

Responsible Party Patient

# MEDICAL / DENTAL HISTORY

In order to provide you with the highest standard of care, we require an accurate and complete MEDICAL/DENTAL HISTORY. Please answer the following questions. You can be assured that all information will be considered CONFIDENTIAL

Name of your Physician:_____Phone #:(_____)_____-_____
Date of your last medical exam_____/_____/_____Findings_____
Are you currently under medical treatment? YES NO For what?_____
Have you ever been hospitalized? YES NO For what?_____

## CHECK IF YOU HAVE BECOME SICK, OR IF YOU ARE ALLERGIC TO:

□ Penicillin □ Erythromycin □ Aspirin □ Xylocaine □ Benzocaine
□ Tetracycline □ Codeine □ Novacaine □ Prilocaine □ Other_____

## HAVE YOU TAKEN ANY MEDICATIONS IN THE PAST 2 YEARS? YES NO

If Yes, please list them MEDICATION PURPOSE
**IMORTANT:** Women,
Include Birth Control Pills
Are You Pregnant?
YES NO

## HAVE YOU EVER HAD ANY OF THE FOLLOWING:

□ Abnormal bleeding
□ Alcohol Abuse
□ Allergies
□ Anemia
□ Artificial Heart Valve
□ Artificial Joints
□ Asthma
□ Blood Transfusion
□ Cancer
□ Colitis
□ Congenital Heart Defect
□ Cosmetic Surgery
□ Diabetes
□ Difficulty Breathing
□ Drug Abuse
□ Emphysema
□ Fainting Spells
□ Fen-Phen
□ Fever Blisters/Cold Sores
□ Frequent Headaches
□ Glaucoma
□ HIV / AIDS
□ Hay Fever
□ Heart Attack
□ Heart Problems
□ Heart Surgery
□ Hemophilia
□ Hepatitis A
□ Hepatitis B
□ Hepatitis C
□ High Blood Pressure
□ Kidney Problems
□ Liver Disease
□ Low Blood Pressure
□ Mitral Valve
□ Osteoporosis
□ Pacemaker
□ Pneumocystis pneumonia
□ Psychiatric Problems
□ Radiation Therapy
□ Rheumatic Fever
□ STD's
□ Seizures
□ Shingles
□ Sickle Cell Disease
□ Sinus Problems
□ Stroke
□ Thyroid Problems
□ Tuberculosis
□ Ulcers
□ Yellow Jaundice

Do you have any disease, condition, or problem not listed? Please explain:_____

Why have you come to the dentist today?_____
Previous dentist name:_____When was your last dental visit?_____
When did you last have X-Rays taken?_____Cleaning?_____
Are you aware of any current dental problems?_____
Do you use tobacco? YES NO type?_____ How Often?_____
Are your teeth sensitive to: □ HOT □ COLD □ SWEETS □ PRESSURE
What condition do you feel your mouth is in? □POOR □ FAIR □ GOOD □ EXCELLENT
What condition do you want your mouth to be in? □POOR □ FAIR □ GOOD □ EXCELLENT
Do you ever have pain or popping noises in your jaw joints? YES NO
Do you grind or clench your teeth at night? YES NO
Do you have extensive daytime drowsiness or fatigue? YES NO
Do you Snore? YES NO
Have you ever been told that you have periodontal disease? YES NO
Have you ever been told that you need crowns or bridgework? YES NO
Are you interested in cosmetically improving your smile? YES NO
Are you currently having pain or discomfort? YES NO
Are you nervous about dental treatment? YES NO
Have you had a bad experience at a dental office? YES NO

All preceding answers are true and correct to the best of my knowledge. If there are any changes in my health, or if my medications change, I will inform the doctor at my next appointment.

Date:_____ Signature:_____