

# Welcome

Thank you for selecting our healthcare team. The following information is important in planning your dental care. Please answer each question as completely as you can. Thank you.

## Patient Information (CONFIDENTIAL)

Soc. Sec. \_\_\_\_\_

Date \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Check Appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated

Patient's or Parents' Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse or Patient's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

If Patient is a Student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Whom May We Thank for Referring You? \_\_\_\_\_ Phone \_\_\_\_\_

Person to Contact in Case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

## Responsible Party

Name of Person Responsible for this Account \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Is this Person Currently a Patient in our Office?  Yes  No Relationship to Patient \_\_\_\_\_

## Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union or Local # \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**DO YOU HAVE ANY ADDITIONAL INSURANCE?**  Yes  No **IF YES, COMPLETE THE FOLLOWING:**

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union or Local # \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Credit Information

We do offer a cash savings if you pay for your services with a check or cash on the same day as your treatment. Payment is expected within 30 days of service unless otherwise arranged. Please discuss with the front office if

you would like to establish credit with our office. Billing charges of 1 1/2% (18% annually) are added to overdue accounts; (90 days). We do reserve the right to report delinquent accounts to the Credit Bureau.

Over Please

# Patient Medical History

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

<p style="text-align: right; margin-right: 20px;">Yes No</p> <p>1. Are you under medical treatment now? ..... <input type="checkbox"/> <input type="checkbox"/></p> <p>2. Have you ever been hospitalized for any surgical operation or serious illness? ..... <input type="checkbox"/> <input type="checkbox"/></p> <p>3. Are you taking any medication(s) including non-prescription medicine? ..... <input type="checkbox"/> <input type="checkbox"/></p> <p>4. If yes, what medication(s) are you taking? _____          _____          _____</p> <p>5. Do you use tobacco? ..... <input type="checkbox"/> <input type="checkbox"/></p> <p>6. Do you wear contact lenses? ..... <input type="checkbox"/> <input type="checkbox"/></p> <p>9. Do you have or have you had any of the following?</p> <table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;"></td> <td style="width: 10%; text-align: center;">Yes</td> <td style="width: 10%; text-align: center;">No</td> <td style="width: 33%;"></td> <td style="width: 10%; text-align: center;">Yes</td> <td style="width: 10%; text-align: center;">No</td> <td style="width: 33%;"></td> <td style="width: 10%; text-align: center;">Yes</td> <td style="width: 10%; text-align: center;">No</td> </tr> <tr> <td>Heart Disease .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Tuberculosis .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Kidney Disease .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> 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High or Low</td> <td></td> <td></td> <td>Drug or Alcohol Addiction ...</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Liver Disease .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Rheumatic Fever.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Malignancies.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Sinus Problems .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Artificial Heart Valve .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Radiation Treatment .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Immune System Depression ..</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Angina (chest pain).....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Epilepsy.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="padding-left: 20px;">(Circle) AIDS, ARC, Organ Transplant</td> <td></td> <td></td> </tr> <tr> <td>Anemia .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Fainting Spells .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td 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type="checkbox"/></td> <td>(explain, please) _____</td> <td></td> <td></td> </tr> <tr> <td>Arthritis.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Emphysema .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>_____</td> <td></td> <td></td> </tr> </table>		Yes	No		Yes	No		Yes	No	Heart Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis .....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint Replacement..	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers .....	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis .....	<input 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Are you allergic to or have you had any reactions to the following .....</p> <p>Local Anesthetics (eg. novocaine)..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Penicillin or other Antibiotics .....</p> <p>Aspirin..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Other .....</p> <p>If yes, explain _____</p> <hr/> <p>8. Women only:</p> <p>Are you pregnant? ..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Are you nursing? ..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Are you taking birth control pills? ..... <input type="checkbox"/> <input type="checkbox"/></p>
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# Patient Dental History

<p style="text-align: right; margin-right: 20px;">Yes No</p> <p>1. When was your last dental exam? _____</p> <p>2. Are you having discomfort now? ..... <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">If yes, explain _____</p> <p>3. Are you satisfied with the appearance of your teeth? ..... <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">If no, explain _____</p> <p>4. Have you been satisfied with your previous dental care? <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">If no, explain _____</p> <p>5. Have you had injuries to your mouth or head? ..... <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">If yes, explain _____</p> <p>6. Do you have any swelling or sores in your mouth? .... <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">If yes, explain _____</p> <p>7. Does food wedge between your teeth? ..... <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">If yes, explain _____</p> <p>8. Do your gums bleed when brushing or flossing?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>3. Have you had prolonged bleeding following extraction? .. <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right; margin-right: 20px;">Yes No</p> <p>10. Are your teeth sensitive to hot or cold? ..... <input type="checkbox"/> <input type="checkbox"/></p> <p>11. Are your teeth sensitive to sweets? ..... <input type="checkbox"/> <input type="checkbox"/></p> <p>12. Do you have a bad taste in your mouth?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>13. Do you have bad breath?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>14. Have you been treated for gum disease?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>15. Have you had your teeth straightened? ..... <input type="checkbox"/> <input type="checkbox"/></p> <p>16. Do you clench or grind your teeth?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>17. Do you hear popping or clicking noise when you chew? ..... <input type="checkbox"/> <input type="checkbox"/></p> <p>18. Do you have the following habits (circle) .... <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Thumbsucking, Fingernail Biting, Mouth Breathing</p> <p>19. Do you have fluoride in your water?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>20. Do you take fluoride tablets?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>21. How often do you brush?..... _____</p> <p>22. How often do you floss?..... _____</p> <p>23. Would you like to keep your natural teeth? .. <input type="checkbox"/> <input type="checkbox"/></p> <p>24. Do you have any questions or concerns? _____</p>
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# Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. 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 and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X \_\_\_\_\_  
 Signature of patient or parent if minor