

Welcome to Our Practice!

Mr. Mrs. Ms. Dr. Last Name: _____ First Name: _____ Middle Initial: _____

Sex/Gender: Male Female Date of Birth: _____ Age: _____ SSN#: _____

Street: _____ Apt: _____ City: _____ State: _____ Zipcode: _____

Email: _____ Home Phone: _____ Cell Phone: _____

Did you find our practice online? Yes No Referred by: _____

Have you ever been a patient of our practice? Yes No Has a family member ever been a patient of our practice? Yes No

Dentist: _____ Medical Doctor: _____

Preferred Pharmacy: _____ Phone: _____

Driver's License #: _____ Nearest relative not living with you: _____

Employer: _____ Work Phone: _____

Personal Payment Type: Cash Check Credit Card

Emergency Contact: _____ Relationship: _____ Phone: _____

Who Will Be Responsible for Your Account

Self (If self, skip section) Spouse Father Mother Other: _____

Name: _____ SSN#: _____ Date of Birth: _____

Phone: _____ Street: _____ Apt: _____ City: _____ State: _____ Zip: _____

DL#: _____ Employer: _____ Phone: _____

Spouse of Other Guarantor Information (if different from above)

Name: _____ Relationship: _____

SSN#: _____ Date of Birth: _____ Phone: _____

Street: _____ Apt: _____ City: _____ State: _____ Zip: _____

Employer: _____ Phone: _____

Insurance Information

Student: Full Time Part Time Not School Name: _____ Address: _____

City: _____ State: _____ Zipcode: _____

Marital Status: Married Divorced Widow Single Legally Separated

Employed: Full Time Part Time Retired Not Do you belong to a PPO or HMO Plan? Yes No

Dental Insurance Information (Primary)

Insurance Type: Dental Medical

Insured's Employer: _____

Dental Insurance Information (Secondary)

Insurance Type: Dental Medical

Insured's Employer: _____

Insured's DOB: _____ Insured's DOB: _____
 Insurance Co: _____ Insurance Co: _____
 Insurance Co Address: _____ Insurance Co Address: _____
 Insurance Phone #: _____ Insurance Phone #: _____
 Group #: _____ Group Name: _____ Group #: _____ Group Name: _____
 Insured's Name: _____ Insured's Name: _____
 Relationship: _____ Sex/Gender: M F Relationship: _____ Sex/Gender: M F
 Date of Birth: _____ SSN#: _____ Date of Birth: _____ SSN#: _____
 Street: _____ City: _____ Street: _____ City: _____
 State: _____ Zip: _____ Phone: _____ State: _____ Zip: _____ Phone: _____

Dental Information

Reason for Today's Visit: _____ Are you in pain? Yes No For how long? _____

Please indicate any of the following problems by checking off the corresponding box:

Discomfort, clicking, or popping in jaw	Lost/broken filling(s)	Stained teeth	Difficulty closing jaw
Red, swollen, or bleeding gums	Teeth grinding/clenching	Locking jaw	Difficulty opening jaw
A removable dental appliance	ringing in ears	Bad breath	Loose/shifting teeth
Blisters/sores in or around mouth	Broken/chipped tooth	Burning tongue/lips	Food caught in teeth
Prolonged bleeding - injury/extraction	Gum disease	Toothache	Swelling in mouth
Recent infections or sore throat	Other: _____		

My teeth are sensitive to: Hot Cold Sweets Biting

Last dental exam: _____ Last dental x-rays: _____ Times/day you brush? _____ Times/week you floss? _____

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best) Would you like whiter teeth? Yes No

What type of toothbrush bristles do you use? Soft Medium Hard

Medical History

Are you in good general health? Yes No Height: _____ Weight: _____ Are you under the care of a physician? Yes No

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes No

Have you had any illness, operation, or been hospitalized in the past five years? Yes No

Have you ever had general anesthesia or IV sedation? Yes No

Have you, or a family member, had any unusual or serious reactions to general anesthesia? Yes No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Rheumatic fever	Heart murmur	Cardiac pacemaker
High blood pressure	Chest pain / Angina	Heart surgery
Low blood pressure	Heart attack(s)	Damaged heart valves
Mitral valve prolapse	Irregular heart beat	

Are you allergic to, or had a reaction to:

Penicillin	Sulfa drugs	Local anesthetic (numbing med)
Amoxicillin	Sodium pentothal/Valium/tranq.	Aspirin
Codeine or other narcotics	Latex	Soy
Eggs /Yolk	Sulfites	Do you have any known allergies?

Please list any other medication or antibiotic you are allergic to: _____

Please list any allergies other than drug allergies: _____

1-4 below for women only: (Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.)

- | | |
|--|---|
| 1. Is there a possibility of pregnancy? Yes No | 3. Are you nursing? Yes No |
| 2. Expected delivery date: _____ | 4. Are you taking birth control pills? Yes No |

Acknowledgement

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

I permit the office to communicate with me via text message on my cell phone.

_____	_____	_____
Signature of patient (Parent or Guardian if Minor)	Reviewed by	Date

Fees & Payments

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorneys fees, and court costs.

_____	_____
Signature of patient (Parent or Guardian if Minor)	Date

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

_____	_____
Signature of patient (Parent or Guardian if Minor)	Date

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____	_____
Signature of patient (Parent or Guardian if Minor)	Date