Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can care for you.

About You

Today's Date _____

Name: _____
Last First MI Mr. Mrs. Ms. Dr.

I prefer to be called: _____ ❑ Male ❑ Female

Birthdate: _____ Age: ____ S.S. #: _____

Home Address: _____
Apt/Condo #

_____
City State Zip

Home #: _____ Pager/Other #: _____

Work #: _____ Ext: ____ DL#: _____

Employer: _____

Employer's Address: _____

How Long There? _____ Occupation: _____

Where & when are best times to reach you? _____

Who may we thank for referring you? _____

Other family members seen by us? _____

Previous/Present Dentist: _____
(circle one)

Last Visit Date: _____

Spouse Information

Name: _____

Employer: _____

Work #: _____ Ext: ____ S.S. #: _____

Birthdate: _____ DL#: _____

Dental History

Why have you come to the dentist today? _____

_____

Are you currently in pain? ❑ Yes ❑ No

Have you ever had a serious/difficult problem associated with any previous dental work? ❑ Yes ❑ No

Have you ever had any pain/tenderness in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you like your smile? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of bristles? ❑ Hard ❑ Medium ❑ Soft

Medical History

CIRCLE ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS YOU HAVE HAD

Anemia/Radiation Treatment	Heart Surgery/Pacemaker
Artificial Bones/Joints	Hemophilia/Abnormal Bleeding
Artificial Valves	Hepatitis
Asthma/Arthritis	HIV+ or AIDS
Blood Transfusion	High/Low Blood Pressure
Cancer/Chemotherapy	Hospitalized for any reason
Congenital Heart Defect	Kidney Problems
Diabetes/Tuberculosis	Mitral Valve Prolapse
Difficulty Breathing	Psychiatric Problems
Drug/Alcohol Problems	Rheumatic Fever
Emphysema/Glaucoma	Severe/Frequent Headaches
Epilepsy/Seizures/Fainting Spells	Shingles
Fever Blisters	Sinus Problems
Heart Attack/Stroke	Ulcers/Colitis
Heart Murmur	Venereal Disease

PLEASE LIST ANY SERIOUS MEDICAL CONDITION(S) THAT YOU HAVE EVER HAD: _____

_____

Physician's Name: _____

Phone #: _____

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

_____

Are you taking any prescription/over-the-counter drugs? ❑ Yes ❑ No

Please list each one: _____

_____

FOR WOMEN

Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No

Are you nursing? ❑ Yes ❑ No

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING DRUGS?

Y N	Penicillin	Y N	Latex
Y N	Dental Anesthetics	Y N	Codeine
Y N	Tetracycline	Y N	Aspirin
Y N	Erythromycin	Y N	Other: (list)

_____

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CONTINUED ON BACK OF FORM

PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthdate: _____ & S.S.#: _____

Insured's Employer: _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthdate: _____ & S.S.#: _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____ Relation: _____

Home #: _____ Work #: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____

Billing Address: _____

_____

City State Zip

Work #: _____ Ext: _____ Home #: _____

Employer: _____

S.S.#: _____ D.L. #: _____

I OR WE AGREE TO BE FINANCIALLY RESPONSIBLE FOR ANY UNPAID BALANCE DUE TO THE HEALTH CARE PROVIDER FOR SERVICES RENDERED.

IF YOU HAVE DENTAL INSURANCE, WE WANT YOU TO RECEIVE THE FULL BENEFIT OF IT. OUR OFFICE STAFF CAN ASSIST YOU IN COMPLETING YOUR INSURANCE FORMS AND VERIFYING THE COVERAGE THAT YOUR PARTICULAR PROGRAM PROVIDES. WE ACCEPT ASSIGNMENT OF YOUR INSURANCE PAYMENT; ANOTHER SERVICE TO YOU. THIS MEANS THAT YOU ARE RESPONSIBLE FOR YOUR DEDUCTIBLE AND THE PORTION THE INSURANCE DOES NOT COVER WHEN YOU SEE THE DOCTOR. REMEMBER, HOWEVER, THAT YOU ARE RESPONSIBLE FOR THE ACCOUNT IF THE INSURANCE COMPANY, FOR ANY REASON, DOES NOT HONOR THEIR COMMITMENT TO YOU AND TO US.

_____ _____

Responsible Party Signature Date

_____ _____

Responsible Party Signature Date

The undersigned, hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

_____ _____

Authorized Signature Date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

_____ _____

Signature Date

OFFICE USE ONLY • OFFICE USE ONLY • OFFICE USE ONLY • OFFICE USE ONLY •

Medical History Update

1. Date: _____ Comments: _____ Signature _____ Dr. Initials _____
2. Date: _____ Comments: _____ Signature _____ Dr. Initials _____
3. Date: _____ Comments: _____ Signature _____ Dr. Initials _____
4. Date: _____ Comments: _____ Signature _____ Dr. Initials _____

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