WELCOME

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PATIENT NAME:_____ HM #:_____ WK #:_____ CELL #:_____
(Please circle best # to reach you: HM WK Cell)
DOB:_____ SS #:_____ GENDER: M F MARITAL STATUS (CIRCLE): MARRIED SINGLE CHILD DIVORCED

E-MAIL ADDRESS_____

HOME ADDRESS:_____ CITY:_____ ZIP CODE:_____

IF PATIENT IS A CHILD, GUARDIAN'S NAME:_____ HM:_____CELL#:_____

SPOUSE'S NAME:_____ WK#:_____ CELL #:_____
Nearest relative not living with you:_____ HM #:_____
Nearest friend not living with you:_____ HM #:_____
Whom may we thank for referring you to us? _____ HM #:_____
Whom may we contact in the case of an emergency? _____ HM #:_____
Who is responsible for the bill (**PLEASE SUBMIT ANY FUTURE CHANGES IN WRITING**) _____ HM #:_____
I WILL BE PAYING TODAY BY: CASH_____ CHECK_____ CREDIT CARD_____

INSURANCE

PRIMARY DENTAL INS. CO. NAME:_____ GROUP # (PLAN, LOCAL, OR POLICY #):_____
ADDRESS:_____ PHONE #:_____
INSURED'S NAME:_____ DOB:_____ SS #:_____ RELATION:_____
INSURED'S EMPLOYER:_____ PHONE #:_____
ADDRESS:_____

SECONDARY DENTAL INS. CO. NAME:_____ GROUP # (PLAN, LOCAL, OR POLICY #):_____
ADDRESS:_____ PHONE #:_____
INSURED'S NAME:_____ DOB:_____ SS #:_____ RELATION:_____
INSURED'S EMPLOYER:_____ PHONE#:_____
ADDRESS:_____

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for the legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the release of any information required to process insurance claims. 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, including those not covered by my insurance carrier.

I understand and agree, regardless of my insurance status, I am ultimately responsible for the balance of my account.. I have read all the information on both sides of this sheet and have completed all the information accurately to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions I may have made in the completion of this form.

PATIENT OR LEGAL GUARDIAN SIGNATURE:_____ **DATE:**_____

PATIENT NAME:_____ **DATE:**_____

PLEASE INDICATE **(X)** ANY OF THE FOLLOWING PROBLEMS:

___Discomfort or clicking in the jaw ___Red, swollen or bleeding gums ___Blisters/sores in or around mouth ___Stained teeth
___Lost/broken fillings ___Teeth grinding/clenching ___Broken or chipped teeth ___Bad breath
___Sensitivity when chewing ___Sensitivity to cold ___Sensitivity to hot

PREVIOUS DENTIST:_____ PHONE #:_____
LAST EXAM:_____ LAST X-RAYS:_____ HOW OFTEN DO YOU BRUSH:_____ FLOSS:_____
WHAT TYPE OF TOOTHBRUSH DO YOU USE? (CIRCLE) SOFT MED HARD

CHECK (X) IF YOU HAVE HAD PROBLEMS WITH ANY OF THE FOLLOWING:

___AIDS/HIV +
___ALLERGIES TO DENTAL ANESTHETIC
___ANAPHYLAXIS
___ANEMIA
___ARTHRITIS/RHEUMATISM
___ARTIFICAL JOINTS-HEART VALVES
___ASTHMA/RESPIRATORY DISEASE
___BACK PROBLEMS
___BLOOD DISEASES-HEMOPHILIA
___CANCER/CHEMOTHERAPY
___CHEMICAL/ALCOHOL DEPENDENCY
___CORTISONE-STEROID TREATMENTS
___DIABETES
___EPILEPSY-SEIZURE DISORDER
___FAINTING
___GENERAL ALLERGIES
___HEADACHES
___HEART MURMUR
___HEART PROBLEMS: DESCRIBE__
_____
___HEPATITIS-TYPE_____
___HERPES/COLD OR CANKER SORES
___HIGH/LOW BLOOD PRESSURE
___JAW PAIN
___KIDNEY DISEASE OR MALFUNCTION
___LATEX ALLERGY
___LIVER DISEASE
___MITRAL VALVE PROLAPSE
___NERVOUS PROBLEMS
___PACEMAKER/HEART SURGERY
___PSYCHIATRIC CARE
___RAPID WEIGHT GAIN/LOSS
___RADIATION TREATMENT
___RHEUMATIC-SCARLET FEVER
___SHORTNESS OF BREATH
___SINUS PROBLEMS
___SKIN RASH
___SNORING-SLEEP APNEA
___STROKE
___SURGICAL IMPLANTS
___THYROID (HYPER/HYPO)
___TOBACCO HABIT
___TUBERCULOSIS
___ULCERS/COLITIS
___VENEREAL DISEASE

DO YOU REQUIRE PREMEDICATION?_____

WHO IS YOUR MEDICAL DOCTOR?_____ PHONE #:_____

LIST ANY OTHER MEDICAL CONDITIONS/SURGERY?_____

DO YOU TAKE ANY MEDICATIONS?____ PLEASE LIST:_____
_____

DO YOU TAKE ANY VITAMINS or HERBAL SUPPLEMENTS?_____

LIST DRUG ALLERGIES, IF ANY:_____

HAVE YOU EVER TAKEN PHEN-FEN OR REDUX?_____

DO YOU SUFFER FROM DENTAL ANXIETY OR KNOWN BEHAVIOR ISSUES?_____ PLEASE LIST: _____
_____

RATE YOUR GENERAL HEALTH 1 – 10_____ ARE YOU HAPPY WITH YOUR SMILE?_____

ARE YOU TAKING BIRTH CONTROL? **Y/N** ARE YOU PREGNANT? **Y/N** HOW LONG?_____ ARE YOU NURSING? **Y/N**