Patient Information

Patient's Name:

_____ _____ _____
Last Name First Name M.I.

Preferred name:_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Child

Social Security #_____

Birthdate:_____ Sex:_____ Age:_____

Address:_____

City:_____ State:_____ Zip:_____

E-mail:_____

Home Phone:_____

Work Phone:_____ Cell Phone:_____

Patient Employer:_____

Spouse's Name:_____

Spouse's Employer:_____

If Patient is a minor Complete Below

Mother's Name:_____ Home #:_____

Work #:_____ Cell #:_____

Father's Name:_____ Home #:_____

Work #:_____ Cell #:_____

Account Information

Person responsible for account

Name:_____

Relationship to patient:_____

Birthdate: _____/_____/_____ Soc. Sec. #:_____-_____-_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone # (___)_____ Work Phone # (___)_____

Employer:_____

Spouse's Name:_____

Spouse's Employer:_____

Dental Insurance

Primary Dental Insurance

Name of Insured:_____

Insured Birthdate: ____/____/____ Soc. Sec. # ____/__/____

Insured Employer:_____

Insured Insurance Company:_____

Group #_____

Secondary Dental Insurance

Name of Insured:_____

Insured Birthdate: ____/____/____ Soc. Sec. # ____/__/____

Insured Employer:_____

Insured Insurance Company:_____

Group #_____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I agree to pay any co-payment amount due at the time of service. I fully understand I am solely responsible for any balance not paid by my insurance company.

*Signature*_____

Billing Information

In order to keep our billing costs and fees lower, payment is expected at time of service unless prior arrangements have been made. Any accounts 60 days or more will receive an 18% annual interest fee applied to your account.

Our methods of payment we offer are listed below.
Please check the option which you prefer.

_____ Cash _____ Personal Check _____ Credit Card
or
_____ Inquire about other financial options

In the Event of Emergency

Who should we contact?

_____

Phone #:_____

Who May We Thank for Referring You to Our Office:

_____

Dental Information

Reason for today's visit:_____

Are you in pain? ☐ No ☐ Yes How Long?_____

Please indicate any of the following problems:

- ☐ Discomfort, clicking or popping in jaw
- ☐ Red, Swollen or bleeding gums
- ☐ Sensitive tooth, teeth or gums
- ☐ Blisters/Sores in or around mouth
- ☐ Other:_____
- ☐ Lost/Broken Filling(s)
- ☐ Teeth Grinding
- ☐ Ringing in Ears
- ☐ Broken/Chipped tooth
- ☐ Stained Teeth
- ☐ Locking Jaw
- ☐ Bad Breath

Do you require pre-medication? ☐ Yes ☐ No ☐ Don't know

Previous Dentist: _____
Name

Last Dental Exam: _____/_____/_____ Last Dental X-Rays: _____/_____/_____

Do you have any concerns about dental treatment?_____

_____

Are you interested in whitening your teeth? ☐ Yes ☐ No Do you use tobacco? ☐ Yes ☐ No

Medical History

Indicate which of the following you have had, or have at the present time. Circle "yes" or "no" to each item.

Yes	No	Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis
Yes	No	Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease
Yes	No	Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.
Yes	No	Heart Murmur	Yes	No	Glaucoma	Yes	No	HIV Positive
Yes	No	High Blood Pressure	Yes	No	Contact Lenses	Yes	No	Blood Transfusion
Yes	No	Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Alcohol/Drug Abuse
Yes	No	Artificial Heart Valve	Yes	No	Tuberculosis	Yes	No	Liver Disease
Yes	No	Heart Pacemaker	Yes	No	Asthma	Yes	No	Neurological Disorder
Yes	No	Rheumatic Fever	Yes	No	Latex Sensitivity	Yes	No	Epilepsy/Seizures/Fainting
Yes	No	Arthritis/Rheumatism	Yes	No	Sinus Trouble	Yes	No	Nervous/Anxious
Yes	No	Stroke	Yes	No	Tumors	Yes	No	Allergies or Hives
Yes	No	Radiation Therapy	Yes	No	Chemotherapy	Yes	No	Kidney Trouble
Yes	No	Artificial Joints (hip, knee, etc.)	Yes	No	Psychiatric Care	Yes	No	Taking Blood Thinners

Please list any other medical condition(s) you have or ever had: _____

_____

Please list name and dosage of any current medications, drugs or pills you are taking: _____

_____

_____

Are you aware of having an allergic reaction to any medications or substance? Yes No If yes, please list:

_____

Medical Doctor_____ Pharmacy _____

Women - Are you pregnant? Yes No _____ Months Are you nursing? Yes No Taking birth control pills? Yes No

Authorization and Release

I authorize doctor or designated staff to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I consent to the use of appropriate medications and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____ ☐ Adult Patient ☐ Parent or Guardian ☐ Spouse Date _____/_____/_____