WELCOME

1 About

Today's Date: ____/____/____ File #

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ ❑Male ❑Female

Date of Birth: ___/___/___ Age: _____ SS# _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone # _____

Work Phone # Ext: _____

Other Phone #'s _____

E-mail Address: _____

Referred By: _____

Employer: How Long? _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: ❑Minor ❑Single ❑Married ❑Divorced ❑Separated ❑Widowed

Spouse's Name: _____

Do you have children? ❑Yes ❑No How Many? _____

2 Insurance

Primary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

Insured's SS # _____

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

Insured's Name: _____

Relation: _____ Date of Birth: __/__/__

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

Insured's SS # _____

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

Insured's Name: _____

Relation: _____ Date of Birth: __/__/__

Insured's Employer: _____

3 Account Info

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____
CITY STATE ZIP

SS #: _____

Drivers License #: _____

Work Phone #: _____

Payment method: ❑Cash ❑Check

_____ ___/___

❑ Credit Card - Enter card # (if accepted)

_____ I hereby authorize assignment of my insurance
Initials rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid for by my insurance company (if offered by this office).

4 In Event of Emergency

Who should we contact? _____

Relation: _____

Home Phone #: _____

Work Phone #: _____

Who is your Medical Doctor? _____

M.D.'s Phone #: _____

PLEASE CONTINUE ON BACK

5 Dental

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation

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

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw	❑ Lost/broken filling(s)	❑ Stained teeth
❑ Red, swollen or bleeding gums	❑ Teeth grinding	❑ Locking jaw
❑ Sensitive tooth, teeth or gums	❑ Ringing in ears	❑ Bad breath
❑ Blisters/sores in or around the mouth	❑ Broken/chipped tooth	

❑ Other: _____

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

Previous Dentist: _____ (____) _____
Name Phone#

Last Dental exam: ___/___/___ Last Dental X-rays: ___/___/___

Times of day you brush? _____ Times a week you floss? _____

What type of tooth brush bristles do you use? ❑ Soft ❑ Medium ❑ Hard

How would you rate your smile? 1 2 3 4 5 6 7 8 9 10

6 Medical

Are you taking any of the following medications? ❑ Nerve Pills ❑ Pain Killers (including aspirin)
❑ Muscle Relaxers ❑ Stimulants ❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s)

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

Y N Heart Attack / Stroke	**Y N** Kidney Problems	**Y N** Cancer/Tumors	**Y N** Chemotherapy
Y N Heart Surg./ Pacemaker	**Y N** Liver Problems	**Y N** Shingles	**Y N** Asthma
Y N Heart Murmur	**Y N** Respiratory Problems	**Y N** Hepatitis	**Y N** Difficulty Breathing
Y N Rheumatic Fever	**Y N** Sinus Problems	**Y N** HIV+/AIDS/ARC	**Y N** Diabetes/Hypoglycemia
Y N Mitral Valve Prolapse	**Y N** Stomach Problems/Ulcers	**Y N** Arthritis/Rheumatism	**Y N** Leukemia
Y N Artificial Valves	**Y N** Psychiatric Problems	**Y N** Artificial Bones/Joints	**Y N** Anemia
Y N Heart Disease	**Y N** Venereal Disease	**Y N** Emphysema	**Y N** High/Low Blood Pressure
Y N Congenital Heart Defect	**Y N** Alcohol/Drug Abuse	**Y N** Fainting/Seizures/Epilepsy	**Y N** Bleeding Problems
Y N Chest Pains	**Y N** Tuberculosis TB	**Y N** Severe/Frequent Headaches	**Y N** Glaucoma
Y N Scarlet Fever	**Y N** Jaw Problems TMJ/TMD	**Y N** Frequent Neck Pain	**Y N** Back Problems

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

Are you allergic to any of the following? ❑ Latex ❑ Penicillin/Amoxicillin ❑ Tetracycline ❑ Asprin
❑ Dental Anesthesia ❑ Others: _____

Do you use tobacco? ❑ No ❑ Yes/How used? _____ How much? _____ How long? _____

Please rate your general health from 1-10: _____ Do you wear contact lenses? ❑ Yes ❑ No

For women: Are you taking Birth Control pills? ❑ Yes ❑ No How many children have **you** Had? _____

Are you Pregnant? ❑ No ❑ Yes/How long? _____ Are you nursing? ❑ Yes ❑ No

I acknowledge that I have received the attached HIPAA Notice of Privacy Practices.

Signature of Patient or Representative _____ Printed Name _____ Date _____

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient.

_____

- 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 provider to release any information required to process insurance claims.
- 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.

Initials ____ Date ___/___/___ Comments _____

Initials ____ Date ___/___/___ Comments _____

Initials ____ Date ___/___/___ Comments _____

Adult Signature

❑ Patient ❑ Parent or Guardian ❑ Spouse _____ Date ___/___/___