PATIENT INFORMATION

Patient Name: ______________________________ Preferred Name ______________
Last First Middle

Date of Birth: ____/____/____ Social Security #: ______________ ❒ Male ❒ Female

Preferred Phone: ______________ This is my (check one): ❒ Home ❒ Cell ❒ Work ❒ Other

Secondary Phone: ______________ This is my (check one): ❒ Home ❒ Cell ❒ Work ❒ Other

Address: ______________________________ City ______________

State and Zip: ______________ Email: ______________

Occupation: ______________________________
Employer Name Address

If you are completing this form for another person, what is your relationship to that person?

Name: ______________ Relation: ______________

REFERRAL: Who can we thank for referring you to our practice?: ______________

EMERGENCY CONTACT: Name: ______________

Relation: ______________ Phone: ______________

DENTAL INFORMATION

Please mark (X) if you have the following:

- ❒ Do your gums bleed when you brush or floss?
- ❒ Are your teeth sensitive to cold, hot, sweet, or pressure?
- ❒ Is your mouth often dry?
- ❒ Have you ever had any periodontal (gum) treatments?
- ❒ Have you ever had any orthodontic (braces) treatment?
- ❒ Do you have any clicking, popping, or discomfort in the jaw?
- ❒ Do you clench your teeth?
- ❒ Do you have or experience sores or ulcers in your mouth?
- ❒ Do you wear a denture or partial denture?
- ❒ Have you ever had a serious injury to your head or mouth?
- ❒ Have you ever had any issues associcated with dental treatment?
  - If yes, describe: ______________
- ❒ Are you currently experiencing dental pain or discomfort? ______________

Date of Last Dental Exam: ________ Purpose of the last (prior) dental visit: ______________

What is the reason for your dental visit today? ______________

How you feel about your smile? ______________

MEDICAL INFORMATION

Are you under the care of a physician? ❒ YES ❒ NO

Physician Name: ______________ Phone: ______________

Date of last physical exam: ______________

Have there been changes in your general health in the past year? ❒ YES ❒ NO

If yes: ______________

Have you had a serious illness, or been hospitalized in the past 5 years? ❒ YES ❒ NO

If yes: ______________

Are you taking any presecription or over the counter medications? ❒ YES ❒ NO

MEDICAL INFORMATION

List all vitamins, natural and herbal supplements, over the counter and prescribed medications:

____

____

____

____

Are you allergic to any food, materials, or drugs? ❐ YES ❐ NO

If yes: ______________________________

Has a physician or dentist recommended that you take antibiotics prior to dental treatment? ❐ YES ❐ NO

Are you taking or scheduled to begin taking an antiresorptive agent (Fosamax, Actonel, Atelvia, Reclast, etc.) for osteoporosis or Paget's disease? ❐ YES ❐ NO

Since 2001, have you been treated or scheduled to begin treatment with an antiresorptive agent (Aredia, Zometra, XGEVA, etc.) for bone pain, complications from Paget's disease, or cancer? ❐ YES ❐ NO

Have you ever had orthopedic total joint replacement? ❐ YES ❐ NO

If yes: Date________________ Doctor ________________ Complications (if any) ________________

Have you ever had artificial (prosthetic) heart valve placement? ❐ YES ❐ NO

If yes: Date________________ Doctor ________________ Complications (if any) ________________

Are you in good health? ❐ YES ❐ NO

Do you use controlled substances? ❐ YES ❐ NO

Do you use tobacco? ❐ YES ❐ NO

Do you drink alcoholic beverages? ❐ YES ❐ NO

Are you currently pregnant? ❐ YES ❐ NO

Due Date: ______________________________

HEALTH HISTORY

Please mark (X) if you have had or currently have any of the following:

- ❐ Heart Disease
- ❐ Heart Attack, Date: _______________
- ❐ Heart Murmur
- ❐ High Blood Pressure
- ❐ Pacemaker
- ❐ COPD
- ❐ Anemia
- ❐ AIDS/HIV Infection
- ❐ Arthritis
- ❐ Hemophilia
- ❐ Autoimmune Disease
- ❐ Asthma
- ❐ Sinus Trouble
- ❐ Cancer / Chemo / Radiation Treatment
- ❐ Chest Pain
- ❐ Chronic Pain
- ❐ Fibromyalgia
- ❐ Diabetes
- ❐ Gastrointestinal Disease
- ❐ GE Reflux / Heartburn
- ❐ Ulcers
- ❐ Thyroid problems
- ❐ Gout
- ❐ Stroke, Date: _______________
- ❐ Glaucoma
- ❐ Hepatitis/Jaundice
- ❐ Liver Disease
- ❐ Epilepsy
- ❐ Fainting/Dizziness
- ❐ Attention Disorders
- ❐ Dementia/Alzheimer's
- ❐ Nervous System Disorders
- ❐ Neurological Disorders
- ❐ Mental Disorders
- ❐ Snoring
- ❐ Infectious Disease
- ❐ Kidney Problems
- ❐ Osteoporosis
- ❐ Migraines
- ❐ Fever Blisters
- ❐ Anxiety

Do you have any other disease, condition, or problem not listed above you'd like us to know about? ____________________

____

To the best of my knowledge, all the preceding information provided is true and correct. If I ever have a change in my health, I understand it is my responsibility to inform the practice at my next visit.

Signature ______________________________ Date ____________________

FINANCING AND INSURANCE

The following information is for the person responsible for payment for the services rendered at this office, and any applicable insurance coverage the patient may have.

Responsible Party:

The Patient (same as above) __________ Patient's Parent / Guardian __________ Other __________

Name ____ Relation to Patient ____________________
Last First Middle

Date of Birth: ________/________/________ Social Security #: ______________________ ❒ Male ❒ Female

Preferred Phone: ______________________ This is my (check one): ❒ Home ❒ Cell ❒ Work ❒ Other

Secondary Phone: ______________________ This is my (check one): ❒ Home ❒ Cell ❒ Work ❒ Other

Address: ____ City ____________________

State and Zip: ______________________ Email: ______________________________

Occupation: ____
Employer Name Address

INSURANCE INFORMATION

PRIMARY

Insured Person's Name: ______________________ Insured's Employer Name: ______________________

Insured's Date of Birth: ______________________ Insurance Group Number: ______________________

Insurance Company Name: ______________________ Insurance Company Phone: ______________________

Insurance Company Address: ____

Insurance ID Number ______________________

SECONDARY

Insured Person's Name: ______________________ Insured's Employer Name: ______________________

Insured's Date of Birth: ______________________ Insurance Group Number: ______________________

Insurance Company Name: ______________________ Insurance Company Phone: ______________________

Insurance Company Address: ____

Insurance ID Number ______________________

Consent for services:

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined prior to treatment. All dental services must be paid for at the time services are performed unless arranged with the office previously.

Patients who carry dental insurance understand that all services are chargeable to the patient and he or she is responsible for payment of all dental services. This office will help prepare, send, collect, and appeal insurance claims and payments as a courtesy to our patients, however the patient is ultimately responsible for ensuring payment is rendered for their services.

In consideration of the professional services rendered to me, I agree to pay the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed, unless objected to in writing, by me, and all costs and reasonable attorney fees if suit be instituted hereunder.

I have read the above conditions of treatment and payment and agree to their content:

Signature: ____ Date: ______________________

Person Completing this Form: ____