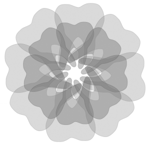

WELCOME TO OUR PRACTICE

Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION...

☐Mr. ☐Mrs. ☐Ms. ☐Dr. First Name ______________________M.I. _____ Last Name ____
Sex: ☐M ☐F Birth Date ___________________ Age _____ Soc. Sec. # ________________________ E-mail: ______________________________
Street Address ______________________________ Apt. _____ City ____________________________ State ___________ Zip ______________
Home Tel: (_____) ________________________ Cell (_____) ________________________ Work Tel: (_____) ______________________
Patient employed by ____ Occupation _____________________________________
Business address ____Business Phone __________________________________
Preferred communication via: ◻ Home tel. ◻ Cell ◻ Work Tel. ◻ Text ◻ E-mail ____________________________________

Whom may we thank for referring you to our practice?

◻ Another patient/friend ◻ Another patient/relative ◻ Dental Office ◻ School ◻ Work ◻ Internet search engine ◻ Mail
◻ Other _____________ Name of person or office referring you to our practice: ____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT...

☐ Self (If Self, skip this section)
Person responsible for account: First Name ________________________M.I. _____ Last Name ____
Relation to patient ____________________________Birth Date ____________________ Age _______ Soc. Sec. # __________________________
Address: *(if different from patient)* ______________________________ Apt. ____ City _______________________ State ______ Zip ____________
Home Tel: (_____) _________________________ Cell (_____) _________________________ Work Tel: (_____) _________________________

INSURANCE INFORMATION...

PRIMARY *DENTAL INSURANCE COMPANY*

Employer ____
Bus. Address _______________City__________State_____ZIP______
Bus. Tel. (_____) ___________________ Plan __________________
Ins Co. Name ______________________ I. D. # _________________
Address (street) _____________________ (city) ________________
(state) _____________ (zip) ________ Tel: (____) ______________
Group # _____________________ Group Name _________________
Insured party (first, last name) ___________________ Relation _______
Sex: ☐ M ☐ F Birth date ____________________ S.S# ____________

SECONDARY/ADDITIONAL *DENTAL INSURANCE COMPANY*

Employer ____
Bus. Address _______________City__________State_____ZIP______
Bus. Tel. (_____) ___________________ Plan __________________
Ins Co. Name ______________________ I. D. # _________________
Address (street) _____________________ (city) ________________
(state) _____________ (zip) ________ Tel: (____) ______________
Group # _____________________ Group Name _________________
Insured party (first, last name) ___________________ Relation _______
Sex: ☐ M ☐ F Birth date ____________________ S.S# ____________

DENTAL INFORMATION...

Reason for today's visit ____________________________________ Are you in pain? ☐ Yes ☐ No, for how long? ____________________________
Previous dentist (name) ____ Address ____
E-mail: ____ Phone: _________________________________ Date of last dental care: ____________
Please check (X) yes or no if you have had problems with any of the following:

☐ Y ☐ N Bad breath
☐ Y ☐ N Bleeding gums
☐ Y ☐ N Clicking or popping jaws
☐ Y ☐ N Food collection between teeth
☐ Y ☐ N Grinding or clenching teeth
☐ Y ☐ N Loose teeth or broken fillings
☐ Y ☐ N Periodontal treatment
☐ Y ☐ N Sensitivity to cold
☐ Y ☐ N Sensitivity to hot
☐ Y ☐ N Sensitivity to sweets
☐ Y ☐ N Sensitivity when biting
☐ Y ☐ N Sores or growths in mouth

How often do you brush teeth ____ Floss? ____
How do you feel about appearance of your teeth? ____
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Y ☐ N
Other information about your dental health or previous treatment ____

MEDICAL HISTORY...

Medical doctor (name) ____ Phone number: ___________________________________
Pharmacy (name) ____ Phone number: ___________________________________
Date of last visit ___________________ Have you had any serious illnesses or operations? ☐ Y ☐ N If, YES please describe ________________
Are you currently under physician care? ☐ Y ☐ N If YES, please describe ____
Have you ever had a blood transfusion? ☐ Y ☐ N If YES, give approximate dates ____
Have you ever taken Fen-Phen/Redux ☐ Y ☐ N Have you, or a relative, had any unusual/serious reactions to general anesthesia? ☐ Y ☐ N
Woman: Are you pregnant? ☐ Y ☐ N Due date ___________________________ Nursing? ☐ Y ☐ N Taking birth control pills ☐ Y ☐ N
Do you smoke? ☐ Yes ☐ No How many cigarettes a day do you smoke? ____

Check (✔) YES if you have had any of the following:

□ ADD or ADHD
□ Autism spectrum disorder
□ AIDS/HIV
□ Atopic allergy
□ Penicillin allergy
□ Codeine allergy
□ Other drug allergy?
____
□ Material allergies (latex, wool)
□ Anemia
□ Arthritis
□ Artificial Joints
□ Asthma
□ Blood Disease
□ Cancer
□ Diabetes
□ Dizziness
□ Epilepsy
□ Excessive Bleeding
□ Fainting
□ Glaucoma
□ Growths
□ Hay Fever
□ Head Injuries
□ Heart Disease
□ Pacemaker
□ Heart Murmur
□ High Cholesterol
□ Hepatitis
□ High Blood Pressure
□ Jaundice
□ Kidney Disease
□ Liver Disease
□ Lupus/Autoimmune
□ Mentally Disabled
□ Mitral valve prolapse
□ Nervous Disorders/ Problems
□ Osteoporosis/ Osteopenia
□ History of taking bisphosphonates
□ Premedication needed
If yes what for? _________
____
□ Radiation Treatment
□ Respiratory Problems
□ Rheumatic Fever
□ Sinus Problems
□ Sexually Transmitted D's
□ Stroke
□ Thyroid Problem
□ Tuberculosis
□ Tumors
□ Ulcers
□ Are you on diet?
□ Contagious diseases
□ Delay in healing
□ Others:
□ ________________________

Is patient currently taking any medications? If yes, list all ____

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help to determine appropriate dental treatment. If there is any change in my medical status, I will inform the dentist. I certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient ____Date ________________________
(Parent or Guardian if Minor)

FEES & PAYMENTS

Payment is due in full at time of treatment, unless prior arrangements have been approved. We make every effort to keep down the cost of your care. You can help by paying your balance upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorney fees, and court costs.

Signature of patient ____Date ________________________
(Parent or Guardian if Minor)

APPOINTMENTS POLICY

We reserve time for you. **There is a charge for broken appointments.** We request a courtesy of notifying our office at least 24 hours prior your scheduled appointment about needing a change. Failure to notify the office less than 24 hours constitutes a broken appointment.

DENTAL INSURANCE ASSIGNMENT OF BENEFITS

I authorize the dental insurance company identified on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the dentist to release all information necessary to secure the payments of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature of patient ____Date ________________________
(Parent or Guardian if Minor)

ACKNOWLEDGEMENT OF PRIVACY PRACTICE

I hereby acknowledge that a copy of the office's Notice of Privacy Practices has been available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of patient ____Date ________________________
(Parent or Guardian if Minor)