WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

1 Personal Information

Date _____

Birthdate _____

SS #/SIN _____ E-Mail _____

Name _____

Prefers to go by _____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address _____ Apartment # _____

City _____ State/ Prov _____ Zip/ PC _____

Employer _____ Occupation _____

Referred by _____

2 Responsible Party

Who is responsible for the account?

Name _____

Relationship to patient _____

Birthdate _____ Driver's License # _____

SS #/SIN _____

Address _____ E-Mail _____

City _____ State/ Prov _____ Zip/ PC _____

Employer _____

Occupation _____

Work Phone _____ Ext. # _____

Home Phone _____ Cell Phone _____

3 Telephone

Home Phone _____

Work Phone _____ Ext. # _____

Cell Phone _____

Please select your preference(s) for being contacted.

☐ Home ☐ Work ☐ Cell ☐ Email _____

In the event of an emergency, who should we contact?

Name _____ Relationship _____ Work # _____ Home # _____

4 Dental Insurance Information

Primary Insurance

Name of Insured _____

Relationship to patient _____

Insured's birthdate _____

SS #/SIN _____

Employer _____

Date Employed _____

Occupation _____

Insurance Company _____

Group # _____

Employee/Cert. # _____

Ins. Co. Address _____

Deductible _____

Amount already used _____

Max. annual benefit _____

Additional Insurance

Name of Insured _____

Relationship to patient _____

Insured's birthdate _____

SS #/SIN _____

Employer _____

Date Employed _____

Occupation _____

Insurance Company _____

Group # _____

Employee/Cert. # _____

Ins. Co. Address _____

Deductible _____

Amount already used _____

Max. annual benefit _____

5 Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

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.

X _____

Signature of patient or parent/guardian if minor Date

6 Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment.

_____ Cash

_____ Personal Check

_____ Credit Card ____ Visa ____ MC

____ Amex ____ Discover

_____ I wish to discuss the dental office's policy.

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed may be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask - we are always happy to help.

Health History

NAME _____ BIRTHDATE _____ TODAY'S DATE _____

A Dental History

1. Reason for visit: _____
2. When was your last dental visit? _____
3. How often do you brush your teeth? _____ Floss? _____
4. What texture brush do you use? ❒ Soft ❒ Medium ❒ Hard

	YES	NO
5. Do your gums bleed while brushing?	❒	❒
6. Do your gums bleed when flossing?	❒	❒
7. Do you feel pain to any of your teeth when brushing or flossing them?	❒	❒
8. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids?	❒	❒
9. Have you noticed any loosening of your teeth?	❒	❒
10. Does food tend to become caught between your teeth?	❒	❒
11. Do you have any sores or lumps in or near your mouth?	❒	❒
12. Have you ever experienced any of the following problems in your jaw?		
a. Clicking?	❒	❒
b. Pain (joint, ear, side of face)?	❒	❒
c. Difficulty in opening or closing?	❒	❒
d. Difficulty in chewing?	❒	❒

	YES	NO
13. Have you had any head, neck or jaw injuries?	❒	❒
14. Do you have frequent headaches?	❒	❒
15. Do you clench or grind your teeth while awake or asleep?	❒	❒
16. Do you bite your lips or cheeks frequently?	❒	❒
17. Have you ever had:		
a. Orthodontic treatment (braces)?	❒	❒
b. Oral surgery?	❒	❒
c. Gum treatment?	❒	❒
d. Your teeth ground or the bite adjusted?	❒	❒
e. Worn a bite plate or other appliance?	❒	❒
18. Are you satisfied with the appearance of your teeth?	❒	❒
19. Have you ever had an upsetting experience in a dental office?	❒	❒
20. Is there anything about having dental treatment that bothers you?	❒	❒

Refer to back of form to explain any responses.

B Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

	YES	NO
1. Are you in good health?	❒	❒
2. Have there been any changes in your general health within the past year?	❒	❒
3. Date of your last physical exam: _____		
4. Physician's name _____ Address _____ Phone No. _____		
5. Are you now under the care of a physician?	❒	❒
6. Have you ever been hospitalized for any surgical operation or serious illness? Please explain. _____	❒	❒
7. Are you taking any medicine(s) including non-prescription medicine? If yes, what medicine(s) are you taking? _____	❒	❒

Refer to back of form for additional room to list medications

	YES	NO
8. Have you had any abnormal bleeding?	❒	❒
9. Do you bruise easily?	❒	❒
10. Have you ever required a blood transfusion?	❒	❒
11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	❒	❒
12. Do you use tobacco? Smoking ❒ Chewing ❒	❒	❒
13. Do you use alcohol?	❒	❒
14 Do you use cocaine or other drugs?	❒	❒
15. Are you wearing contact lenses?	❒	❒
16. Do you have any disease, condition or problem not listed above that you think I should know about?	❒	❒

Women Only:

1. Are you pregnant or think you may be pregnant?	❒	❒
2. Are you nursing?	❒	❒
3. Are you taking birth control pills?	❒	❒

(OVER)

C Medical History Continued...

	YES	NO
Are you allergic to or have you had reactions to:		
1. Local anesthetics like novocaine?	❒	❒
2. Antibiotics?	❒	❒
If so, which ones_____		
3. Sulfa drugs?	❒	❒
4. Barbiturates?	❒	❒
5. Aspirin?	❒	❒
6. Other?_____	❒	❒
Do you have or have you ever had the following:		
1. Rheumatic heart disease or rheumatic fever?	❒	❒
2. Scarlet fever?	❒	❒
3. Heart defect or heart murmur?	❒	❒
4. Heart trouble, heart attack or angina?	❒	❒
a. Do you have pain in your chest upon exertion?	❒	❒
b. Are you ever short of breath after mild exercise?	❒	❒
c. Do your ankles swell?	❒	❒
d. Do you get short of breath when you lie down?	❒	❒
e. Do you require extra pillows when you sleep?	❒	❒
5. Pacemaker?	❒	❒
6. Heart surgery?	❒	❒
7. High blood pressure?	❒	❒
8. Low blood pressure?	❒	❒
9. Hepatitis, jaundice or liver disease?	❒	❒
10. Stroke?	❒	❒
11. Sinus trouble?	❒	❒
12. Lung or breathing problems?	❒	❒
13. Asthma or hay fever?	❒	❒
14. Hives or skin rash?	❒	❒
15. Fainting spells or seizures?	❒	❒
16. Diabetes?	❒	❒
17. AIDS or HIV infection?	❒	❒
18. Thyroid problems?	❒	❒
19. Allergies?	❒	❒
20. Arthritis or rheumatism?	❒	❒
21. Joint replacement or implant?	❒	❒
22. Stomach ulcer?	❒	❒
23. Kidney trouble?	❒	❒
24. Tuberculosis?	❒	❒
25. Persistent cough?	❒	❒
26. Cough that produces blood?	❒	❒
27. Cancer?	❒	❒
28. Sexually transmitted disease?	❒	❒
29. Epilepsy?	❒	❒
30. Anemia?	❒	❒
31. Leukemia?	❒	❒
32. Glaucoma?	❒	❒

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

Additional Comments:

USE THIS SPACE FOR ADDITIONAL MEDICATION LISTING

_____

_____

_____

_____

PLEASE USE THIS SPACE TO EXPLAIN ANY RESPONSES IN THE DENTAL HISTORY SECTION / MEDICAL HISTORY SECTION.

_____

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