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.

Patient Information (Confidential)

*Name*_____ *Birthdate*_____ *SS#*_____
Check appropriate box: ☐ *Minor* ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed*
*Address*_____ *City*_____ *State*_____ *Zip*_____
*Home phone*_____ *Mobile phone*_____ *E-mail address*_____
How do you prefer to be reminded of your appointments?
Check appropriate box: ☐ *Home* ☐ *Work* ☐ *Cell* ☐ *E-mail* ☐ *Text*
Full-time Student: ☐ *Yes* ☐ *No* *If Yes, name of school/college*_____
*Address*_____ *City*_____ *State*_____ *Zip*_____
*Employer*_____ *Work phone*_____ *x*_____
*Whom may we thank for referring you?*_____
*Person to contact in case of an emergency*_____ *Phone*_____
*Address*_____ *City*_____ *State*_____ *Zip*_____
*Closest relative not living with you*_____ *Phone*_____
*Address*_____ *City*_____ *State*_____ *Zip*_____

Responsible Party (If Patient is a child)

*Name*_____ *Birthdate*_____ *SS#*_____
*Address*_____ *City*_____ *State*_____ *Zip*_____
*Home phone*_____ *Mobile phone*_____ *E-mail address*_____
*Employer Name*_____ *Work Phone*_____ *x*_____
*Employer address*_____ *City*_____ *State*_____ *Zip*_____
Payment is expected as services are rendered unless prior financial arrangements have been made. For your convenience, we offer the following methods of payment: Cash, Personal Check, Visa, Master Card, Discover, or ask us about interest free credit which may be obtained through Care Credit for balances over $300.

Primary Dental Insurance

*Name of insured*_____ *Relationship to patient*_____
*Birthdate*_____ *SS#/ID#*_____ *Group number*_____
*Employer*_____
*Insurance company*_____ *Phone number*_____
*Address*_____ *City*_____ *State*_____ *Zip*_____

If you have additional dental insurance, complete the following:

*Name of insured*_____ *Relationship to patient*_____
*Birthdate*_____ *SS#/ID#*_____ *Group number*_____
*Employer*_____
*Insurance company*_____ *Phone number*_____
*Address*_____ *City*_____ *State*_____ *Zip*_____

Patient Medical Information

Physician_____ Office Number_____

	Yes	No
Are you under medical treatment now?	☐	☐
If yes, please list: _____		
Are you taking any medication for osteoporosis?	☐	☐
If yes, please list: _____		
Are taking a blood thinning medication?	☐	☐
If yes, please list: _____		
Are you taking any other medications at this time?	☐	☐
If yes, please list:		

	Yes	No
Do you have any allergies to medications, Latex, metals, iodine?	☐	☐
If yes, please list: _____		

Women only:

	Yes	No
Are you pregnant?	☐	☐
If yes, what month _____		
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

_____ _____ _____ _____

_____ _____ _____ _____

Do you have or have you had any of the following:

	Yes	No		Yes	No		Yes	No
Heart Failure	☐	☐	Tuberculosis	☐	☐	Anemia	☐	☐
Heart Disease or Attack	☐	☐	Emphysema	☐	☐	Rheumatic Fever	☐	☐
Hepatitis / Jaundice	☐	☐	Angina	☐	☐	Diabetes	☐	☐
High Blood Pressure	☐	☐	Cancer	☐	☐	Pacemaker	☐	☐
Low Blood Pressure	☐	☐	Sexually Transmitted Disease	☐	☐	A.I.D.S.	☐	☐
Mitral Valve Prolapse	☐	☐	Hay Fever / Allergies	☐	☐	Arthritis	☐	☐
Heart Murmur	☐	☐	Drug Addiction	☐	☐	Respiratory Problems	☐	☐
Artificial Joints / Valves	☐	☐	Stroke	☐	☐	Fainting / Seizures	☐	☐
Scarlet Fever	☐	☐						

Patient Dental Information

	Yes	No
Date of last dental exam _____		
Do your gums bleed while brushing or flossing?	☐	☐
Are your teeth sensitive to hot or cold?	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
Do you feel pain in any of your teeth?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Have you had any neck or jaw injuries?	☐	☐
Have you experienced any of the following problems in jaw:	☐	☐
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening and closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
Do you have frequent headaches?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you bite your lips or cheek frequently?	☐	☐
Have you had orthodontic treatment (braces)?	☐	☐
Do you like your smile?	☐	☐
Would you be interested in hearing about the variety of options available for improving the appearance of your teeth?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. The undersigned hereby authorizes Doctor and staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic embodies a certain risk. I authorize Doctor 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 health practioners. I authorize my insurance company to pay all dental benefits to the doctor. I understand that my dental insurance carrier may pay less than the actual bill for services and I agree to be responsible for payment of all services rendered on my behalf or my dependents. I further understand that a finance charge of 1.5% per month (18% APR) may be added to any balance over 60 days. I promise to pay collection costs and reasonable attorney fees as may be required to effect collection of this note.

_____ _____

Signature Date