

A CARING DENTAL GROUP



PATIENT INFORMATION

CIRCLE ONE: Dr./Mr./Mrs./Ms./Miss MALE / FEMALE

FIRST: _____ MIDDLE: _____ LAST: _____ Jr/Sr: _____

PREFERRED NAME: _____

IF CHILD, PARENT'S NAME: _____ MIDDLE: _____ LAST: _____

STREET: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK (IF ABLE TO CONTACT): _____

CELL PHONE: _____ EMAIL: _____

PATIENT SOCIAL SECURITY NUMBER: _____ - _____ - _____ PATIENT D.O.B: ____/____/____

EMERGENCY CONTACT: _____ PHONE: _____

HOW DID YOU HEAR ABOUT US? FLYER REFERRAL: _____

OTHER FAMILY MEMBERS IN PRACTICE: _____

INSURANCE INFORMATION

DO YOU HAVE DENTAL INSURANCE? (circle) YES NO

	<i>PRIMARY INSURANCE</i>
Subscriber Name	
Subscriber SSN	
Date of Birth	
Relationship to Subscriber	<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD OTHER _____
Employer Name	
Employer Phone	
Insurance Company	
Insurance Group #	
Insurance Phone #	

RELEASE

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another Dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENTS OR GUARDIANS SIGNATURE _____

DATE _____

PATIENT'S NAME: _____ **DOB:** ____/____/____

ARE YOU UNDER THE CARE OF A PHYSICIAN? (circle) **YES NO** LAST PHYSICAL DATE: _____

PHYSICIAN'S NAME: _____ ADDRESS OR PHONE #: _____

DATE OF LAST DENTAL VISIT: _____ WHAT WAS DONE AT THAT TIME? _____

PREVIOUS DENTIST NAME & ADDRESS: _____ DATE OF LAST CLEANING: ____/____/____

HAVE YOU TAKEN ANTIBIOTICS PRIOR TO DENTAL TREATMENT PROCEDURES IN THE PAST? (CIRCLE) **YES NO**

HAVE YOU HAD ANY PROBLEMS WITH PENICILLIN, ANTIBIOTICS, ANESTHETICS, OTHER MEDICATIONS, OR METALS OR LATEX?(CIRCLE) **YES NO**

ARE YOU CURRENTLY PREGNANT? **YES NO**

CURRENTLY TAKING BIRTH CONTROL? **YES NO**

List any medications you are allergic to:

1. _____ 2. _____ 3. _____

List any medications you are taking (including non-prescription drugs and birth control):

1. _____ 2. _____ 3. _____

DENTAL HISTORY

Do you have any history of:	Y	N		Y	N		Y	N
Have you made regular visits? How Often?			Do you have frequent headaches, neck aches, or shoulder aches?			Do your gums bleed or hurt?		
Were Dental X-Rays taken?			Does food get caught in your teeth?			Have you had any orthodontic work?		
Have you lost any teeth or have they been removed?			Are you sensitive to: Hot? Cold? Sweet? Pressure?			Are any of your teeth loose, tipped, shifted, or chipped?		
Have they been replaced? Perm Bridge ____ Age ____ Removable ____ Age ____ Dentures ____ Age ____ Implants ____ Age ____			Have you ever had gum treatment or surgery? A. What? _____ B. Where? _____ C. When? _____			Have you ever had any unpleasant dental experiences in the past? If so, explain:		
Are you happy with the replacement?			Have you experienced any soreness in the muscles around your ears?			How often do you brush? _____		
Would you like to know more about permanent replacements?			Does your jaw click or pop?			Do you floss? How Often?		
Have you ever had any complications or problem with previous replacements?			Do you clench or grind teeth?			COMMENTS OR CONCERNS:		

MEDICAL HISTORY

Do you have a history of:	Y	N		Y	N		Y	N	Y	N		
Rheumatic Fever			Asthma			Thyroid Disease			Liver Disease			
Heart Murmur			Allergies or Hives			Epilepsy or seizures			Kidney Disease			
Mitral Valve Prolapse			Anemia/Leukemia			Fainting or Dizzy Spells			Dialysis			
Diabetes			Aspirin			Ulcers or stomach problems			Chemotherapy			
Pace Maker			Venereal Disease			Arthritis			Radiation Treatment			
High Blood Pressure			HIV / AIDS			Latex Allergy			Use of Tobacco			
Low Blood Pressure			Blood Transfusion			Sinus Problems			Drug Addiction			
Heart Problem			Excessive Bleeding			Cancer: ()			Psychiatric Treatment			
Stroke			Hepatitis			Breathing Problems			Blood Disorder			
Lung Disease			Tuberculosis			Artificial Joints/Prosthesis			Artificial Heart Valve Implant Or pacemaker? Y or N			
						Blood Disorder						
COMMENTS OR CONCERNS:				Do you consume Alcoholic Beverages								
				Other Major Surgeries:						Ever had Botox or Derma fillers?		

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge.

PATIENT'S SIGNATURE: _____ **DATE:** _____

DR'S SIGNATURE: _____ **DATE:** _____