Welcome
Welcome
Welcome

WELCOME TO OUR PRACTICE

PATIENT INFORMATION

Date ____________

1.IP

❏ Mr. ❏ Mrs. ❏ Ms. ❏ Dr. First Name ____________ Middle ____ Last Name ____________ Nickname ____________

Sex: ❏ Male ❏ Female Birth Date ________ Age ____ Soc. Sec. # ____________ E-mail ____________

Street ____________ City ____________ State ______ Zip ______

Home Tel. (____) ____________ Cell. (____) ____________ Circle your preferred contact? Home Work Cell Email

Referred By ____________ FIRST NAME ____________ LAST NAME Has a family member ever been a patient of our practice? ❏ Yes ❏ No

Previous Dentist ________ FIRST NAME ________ LAST NAME Medical Doctor ________ FIRST NAME ________ LAST NAME Orthodontist ________ FIRST NAME ________ LAST NAME

Driver's Lic.# ____________ Nearest relative not living with you ________ FIRST NAME ________ LAST NAME Tel. (____) ________

Employer ____________ Bus. Tel. (____) ____________ Personal Payment Type: ❏ Cash ❏ Check ❏ Credit Card

Who will be responsible for your account?

(If self, skip to next section)

❏ Self ❏ Spouse ❏ Father ❏ Mother ❏ Other ____________

Name ________ FIRST NAME ________ LAST NAME S.S.# ____________ Birth Date ________ Age ____ Tel. (____) ________

Street ____________ City ____________ State ______ Zip ______

Employer ____________ Bus. Tel. (____) ________

Spouse or other guarantor information (*if different from above*)

Name ________ FIRST NAME ________ LAST NAME Relation ________ S.S.# ____________ Birth Date ________

Street ____________ City ____________ State ______ Zip ______

Tel. (____) ____________ Employer ____________ Bus. Tel. (____) ________

INSURANCE INFORMATION

1.IO

Student: ❏ Full Time ❏ Part Time ❏ Not School Info ____________ SCHOOL NAME ____________ ADDRESS

❏ Married ❏ Divorced ❏ Legally Separated ❏ Widow ❏ Single ____________ CITY ______ STATE ______ ZIP

Employed: ❏ Full Time ❏ Part Time ❏ Retired ❏ Not Do you belong to a PPO or HMO? ❏ Yes ❏ No

PRIMARY DENTAL INSURANCE COMPANY

❶

Employer ____________

Bus. Address ________ ADDRESS ________ CITY ____ STATE ____ ZIP

Bus. Tel. (____) ____________ Plan ____________

1.I1

Ins. Co. Name ____________

Address ____________ ADDRESS

________ CITY ____ STATE ____ ZIP Tel. (____) ________

Group # ________ **Group Name** ________

Insured Party ________ FIRST NAME ________ LAST NAME Relation ________ self/spouse/child/other

Sex: ❏ M ❏ F Birth Date ________ S.S. # ________

Address ____________

________ CITY ____ STATE ____ ZIP

Tel. (____) ____________ I.D. # ________

PRIMARY MEDICAL INSURANCE COMPANY

Employer ____________

Bus. Address ________ ADDRESS ________ CITY ____ STATE ____ ZIP

Bus. Tel. (____) ____________ Plan ____________

Ins. Co. Name ____________

Address ____________ ADDRESS

________ CITY ____ STATE ____ ZIP Tel. (____) ________

Group # ________ **Group Name** ________

Insured Party ________ FIRST NAME ________ LAST NAME Relation ________ self/spouse/child/other

Sex: ❏ M ❏ F Birth Date ________ S.S. # ________

Address ____________

________ CITY ____ STATE ____ ZIP

Tel. (____) ____________ I.D. # ________

SECONDARY DENTAL INSURANCE COMPANY

❷

Employer ____________

Bus. Address ________ ADDRESS ________ CITY ____ STATE ____ ZIP

Bus. Tel. (____) ____________ Plan ____________

Ins. Co. Name ____________

Address ____________ ADDRESS

________ CITY ____ STATE ____ ZIP Tel. (____) ________

Group # ________ **Group Name** ________

Insured Party ________ FIRST NAME ________ LAST NAME Relation ________ self/spouse/child/other

Sex: ❏ M ❏ F Birth Date ________ S.S. # ________

Address ____________

________ CITY ____ STATE ____ ZIP

Tel. (____) ____________ I.D. # ________

SECONDARY MEDICAL INSURANCE COMPANY

Employer ____________

Bus. Address ________ ADDRESS ________ CITY ____ STATE ____ ZIP

Bus. Tel. (____) ____________ Plan ____________

Ins. Co. Name ____________

Address ____________ ADDRESS

________ CITY ____ STATE ____ ZIP Tel. (____) ________

Group # ________ **Group Name** ________

Insured Party ________ FIRST NAME ________ LAST NAME Relation ________ self/spouse/child/other

Sex: ❏ M ❏ F Birth Date ________ S.S. # ________

Address ____________

________ CITY ____ STATE ____ ZIP

Tel. (____) ____________ I.D. # ________

HEALTH HISTORY

To our patients: Although dentists 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 care, that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason for today's office visit

	Yes	No
99. Are you in good health? Height Weight	❏	❏
100. Have there been any changes in your general health in the past year?	❏	❏
101. Are you under the care of a physician? Date of last visit *If so, for what are you being treated?*	❏	❏
102. Have you had any illness, operation or been hospitalized in the past five years? *If so, describe*	❏	❏
103. Do you have unhealed/recurrent injuries or inflamed areas, growths or sore spots in or around your mouth? *If so, describe where*	❏	❏
104. Do you have a prosthetic joint/implant? *If so, describe where*	❏	❏
105. Have you had a heart valve replacement or vascular graft?	❏	❏

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE. . .	Yes	No	NOTES
106	Rheumatic fever?			
107	Damaged heart valves / mitral valve prolapse?			
108	Heart murmur?			
109	High blood pressure?			
110	Low blood pressure?			
111	Chest pain / angina?			
112	Heart attack(s)?			
113	Irregular heart beat?			
114	Cardiac pacemaker?			
115	Heart surgery?			
116	Pneumonia, bronchitis, chronic cough?			
117	Asthma?			
118	Hay fever / sinus problems?			
119	Snoring / sleep apnea?			
120	Difficult breathing / other lung trouble?			
121	Tuberculosis?			
122	Emphysema?			
123	Do you smoke? If so, # packs a day ______			
124	Do you use chewing tobacco?			
125	Blood transfusion?			
126	Blood disorder such as anemia?			
127	Bruise easily?			
128	Bleeding tendency / abnormal bleed?			
129	Hepatitis, jaundice, or liver disease?			
130	Infectious mononucleosis?			
131	Gallbladder trouble?			
132	Fainting spells?			
133	Convulsions / epilepsy?			
134	Stroke?			

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE. . .	Yes	No	NOTES
135	Thyroid trouble?			
136	Diabetes?			
137	Low blood sugar?			
138	Kidney trouble?			
139	Are you on dialysis?			
140	Swollen ankles, arthritis or joint disease?			
141	Osteoporosis / Osteopenia?			
142	Osteonecrosis?			
143	Stomach ulcers?			
144	Contagious diseases?			
145	Sexually transmitted diseases?			
146	Are you immunosuppressed? possibly from transplant surgery, etc.			
147	Problems with the immune system? possibly from medication / surgery, etc.			
148	Delay in healing?			
149	A tumor or growth?			
150	Cancer / radiation therapy chemotherapy?			
151	Chronic fatigue / night sweats?			
152	Are you on a diet?			
153	A history of drug abuse?			
154	A history of alcohol abuse?			
155	Contact lenses?			
156	Eye disease / glaucoma?			
157	Mental health problems?			
158	A removable dental appliance?			
159	Pain and clicking of jaws when eating?			
160	Have you, or a family member, had any unusual or serious reactions to general anesthesia?			

Please Note: All numbering is not sequential.

MEDICATION – Are you now taking. . .

		Yes	No	NOTES
201	Any kind of medication, drug, pills?			
202	Blood thinners (Coumadin, Plavix Aspirin, Vitamin E, Ginko Biloba)?			
203	Have you ever taken diet pills?			
204	Any natural product, herbal supplement or homeopathic remedy?			
205	Have you ever taken any bone density medications / Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)?			

206 Have you ever taken tranquilizers, sleeping pills, anti depressants, and / or narcotics on a regular basis? If so, please list:

207 Please list any medications you are currently taking and for what?

MEDICATION	*DOSAGE*	*FREQUENCY*	*MEDICATION*	*DOSAGE*	*FREQUENCY*

ALLERGIES – Are you allergic to, or had a reaction to. . .

		Yes	No	NOTES
208	Local anesthetic (numbing med.)?			
209	Penicillin?			
210	Other antibiotics?			
211	Sulfa Drugs?			
212	Sodium pentothal, Valium, or other tranquilizers?			
213	Aspirin?			
214	Codeine or other narcotics?			
215	Other medications?			
216	Latex?			
217	Soy?			
218	Eggs / Yolk?			
219	Sulfites?			

220 Please list any allergies other than drug allergies:

IF YOU ARE HAVING SURGERY TODAY, have you had anything to eat or drink in the last 6 hours? ❏ Yes ❏ No

Who is driving you home?______________________________

Is there any condition concerning your health that the Doctor should be told about?
❏ Yes ❏ No (*if so, describe*)

Do you wish to speak to the doctor privately about anything?
❏ Yes ❏ No

Is there a **FAMILY HISTORY** of:

301 **Cancer:**	❏ Yes ❏ No
302 **Diabetes:**	❏ Yes ❏ No
303 **Heart Disease:**	❏ Yes ❏ No
304 **Anesthetic Problems:**	❏ Yes ❏ No

IN CASE OF EMERGENCY, CONTACT:

Name______________________________

Home Tel.(______) ________________ Bus. Tel.(______) ________________

IS THIS VISIT RELATED TO AN ACCIDENT?

Date of Injury ____________________

Automobile:	❏ Yes	❏ No
Work Related	❏ Yes	❏ No
Other:	❏ Yes	❏ No

Insurance company handling this claim________________________

Claim number______________________________

Name of Attorney / Adjustor ________________________

Telephone Number (______) ________________________

THIS SECTION (401-404) IS FOR WOMEN ONLY, MEN CONTINUE BELOW. WOMEN, CONTINUE BELOW WHEN YOU HAVE COMPLETED THIS SECTION.

401 Is there a possibility of pregnancy? ❏ Yes ❏ No

402 Expected delivery date _____ / _____ / _____

403 Are you nursing? ❏ Yes ❏ No

404 Are you taking birth control pills? ❏ Yes ❏ No

Women Note: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.*

I certify that I have answered all questions truthfully and to the best of my knowledge in order for the dentist to provide me dental care in a safe manner. It is my responsibility to update any changes to the above information. I will not hold the dentist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Signature of Patient: *(Parent or Guardian if minor)* **X** **Reviewed by: X** **Date: X**

FEES AND PAYMENTS

I agree to pay for all dental services provided to me or my dependents, due and payable at time of service unless prior arrangements have been made. I'm responsible for paying any deductible, co-insurance or any other balance not paid by my insurance plan. If payments are not received upon due date, I understand that a 1.5% monthly finance charge (18% APR) may be added to my account, in addition to any late charges. I will also be responsible for all collection costs, attorney fees, and court costs.

such ways, my name and personal information will be kept confidential. I do not expect compensation, financial, or otherwise, for the use of these images.
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, attorneys fees, and court costs.

Signature of Patient: *(Parent or Guardian if minor)* **X** **Date: X**

This signature on file is my authorization to direct payment of the dental/medical insurance benefits otherwise payable to me, directly to the above named dental entity. This assignment of benefits will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be as valid as the original.

Signature of Datient: *(Parent or Guardian if minor)* **X** **Date: X**

AUTHORIZATION

I authorize the doctor to order appropriate X-rays, study models, videos/photographs, or other diagnostic aids for the purpose of diagnosis and treatment planning.I consent that images of the patient's face, jaw, and teeth may be shown to others for treatment purposes, lectures, journals, or advertisements (website, newspapers, magazines, etc.) but name and personal information will be kept confidential. I DO NOT expect compensation, financial, or otherwise, for the use of such images.

X **Date**

X **Signature of Datient** *(Parent or Guardian if minor)*

Witness: X

Doctor: X

I Ui h\cf]nY h\Y XcWhcf hc dYfZcfa U`` hfYUha Ybh UbX UbmWUb[Yg a i h U`mU[fYYX i dcb Vma Y UbX hc i gY h\Y UddfcdfJUhY a YX]VUh]cb#h\YffUdm]bX]VUhYX Zcf gi W hfYUha Ybh" = understand that using anesthetic agents embodies certain risks. I also authorize doctor to choose and employ such assistance as deemed fit to provide the recommended treatment.

Signature of Datient: *(Parent or Guardian if minor)* **X** **Date: X**