Patient Information

Name _____ Birth date _____
First MI Last
Address: _____City_____State_____Zip_____

SS# _____Status: Married Single Other

Home phone# _____Work phone #_____

Cell phone# _____Email _____

How did you hear about us? _____How long have you lived in the area? _____

Occupation _____

Name of spouse _____ Spouse's occupation _____

Children:

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Person to contact in case of emergency _____Phone#_____

Relatives who live in the area? __ Parent(s) __ Brother(s)/Sister(s) __ Grandparent(s) ___ Other ____

Is a monthly payment plan important for assisting in your treatment? _____

Cost of treatment has different ranges depending on the type of case, length of time and severity of dental procedures needed. Our office makes financial plans and effort to assist you and your family to obtain the treatment you need.

We offer a couple of patient funding services such as CareCredit and Lending Club.

Please let us know what works best to fit your needs.

Responsible Party

Name of subscriber of the dental policy_____
First MI Last

Relationship to patient _____Subscriber SS#_____DOB_____

Employer phone #_____ Employer Name_____

Insurance Information

Name of Insurance Company _____Policy ID#_____

Group ID#_____ Insurance phone #_____

Insurance address: _____
Address City State Zip Code

Dental History

General Dentist _____Phone #_____

Reason for today's visit_____

What is your goal from today's visit? _____

Do you like your smile? _____

Date of last exam _____Date of last dental X-rays_____

How often do you brush? _____How often do you floss?_____

Do you need to be pre-medicated before dental procedure? _____

Do you feel apprehensive when you are having dental treatment? _____

Please check any of the following conditions that apply to you:

□ Bad Breath	□Grinding Teeth	□Sensitivity to hot/sweet
□ Bleeding Gums	□Loose teeth or broken fillings	□Biting your cheek
□Clicking or popping jaw	□Periodontal treatment	□ Sensitivity when biting
□Food collection between teeth	□ Sensitivity to cold	□ Sores or growths
□Dry mouth	□ Jaw pain	□Cold sores

Medical History

Physician Name_____ Phone#_____

You would best describe your general health as: GOOD FAIR POOR

Are you under the care of a physician? _____ If yes, what is the condition?_____

Please indicate any major hospitalization/operation or illness _____

Women Only: Are you pregnant? □ Yes □ No Are you nursing? □Yes □No
Taking birth control? □Yes No □ what form of birth control _____

Do you have a history of the following?

□HIV/AIDS
□Anemia
□Arthritis/Rheumatism
□Artificial Joints
□Asthma
□Back Problems
□Blood Disease
□Cancer (if yes)
□Chemotherapy
□Radiation Treatment
□Circulatory Problems
□Skin Rash
□Tobacco Habit
□Low Blood Pressure
□Steroid treatment
□Diabetes
□Venereal disease
□Epilepsy
□Glaucoma
□Headaches
□Heart Murmur
□Hemophilia
□Hepatitis
□High Cholesterol
□Hypertension
□Stroke
□Tuberculosis
□Sinus Problem
□Autoimmune disease
□Kidney Disease
□Liver Disease
□Nervous Problems
□Pacemaker
□Psychiatric Care (if yes)
□ Anti anxiety medications _____
□ Recreational Drugs (if yes)
□ Marijuana
□ Other_____
□Congestive Heart Failure
□Respiratory Disease / Cough
□Rheumatic Fever / Rheumatic Heart Disease
□Heart Attack
□Shortness of Breath
□Thyroid Problems
□Stomach Ulcers
□Herpes / Shingles
□Osteoporosis

Please answer the following questions:	Yes	No
Does anyone in your immediate family have a history of the above conditions? If YES, please explain_____	□	□
Do you have any other medical condition that hasn't been mentioned? If YES, please explain_____	□	□

	Yes	No
Do you take a **Bisphosphonate**?	□	□

(Bisphosphonate - A class of drugs that prevent the loss of bone mass, used to treat osteoporosis and similar diseases)

If YES explain what type and how long _____

Do you snore?	□	□
Do you have sleep apnea?	□	□
Do you have high blood pressure?	□	□
Has anyone reported that you choke or gasp for air while sleeping?	□	□
Do you wake refreshed?	□	□
Are you excessively tired during the day?	□	□

List all prescribed medications you are currently taking:_____

List all over the counter medications you are currently taking: _____

Allergies: □ Food □ Drugs □ Latex □ Metals □ Other: _____

Please describe: _____

Nature of reaction: _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. 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 payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

SIGNATURE OF PATIENT (or parent if a minor) DATE