WELCOME

ABOUT YOU

Today's Date: ___/___/___

Patient Name: _____

Name:_____

LAST FIRST MI

What You Prefer To Be Called: _____

Birthdate: ___/___/____Age: _____SS#:_____

Mailing Address: _____

_____

CITY STATE ZIP

Home Phone #: (_____) _____

Work Phone #: (_____) _____Ext:_____

Cell Phone #: (_____) _____

E-mail Address: _____

Employer: _____

Employers Address: _____

CITY ZIP

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name: _____

Do you have children? ☐ Yes ☐ No How many? _____

INSURANCE INFO

Primary Dental Insurance

Co. Name:_____

Address :_____

_____

CITY STATE ZIP

Phone #: (_____)_____

Insured's ID #:_____

Group #:_____

Insured's Name:_____

Relation:_____ Date of Birth:___/___/___

Insured's Employer:_____

Secondary Dental Insurance

Co. Name: _____

Address: _____

_____

CITY STATE ZIP

Phone #: (___)_____

Insured's ID#:_____

Group #: _____

Insured's Name:_____

Relation: _____Date of Birth:___/___/___

Insured's Employer:_____

ACCOUNT INFO

Person ultimately responsible account

Name :_____

Relation: _____

Billing Address : _____

_____

CITY MI ZIP

SS#: _____

Drivers License #: _____

Work Phone #: (___) _____

Payment method: ☐ Cash ☐ Check

_____ ____ /_____

☐ Credit Card – Enter Card # above (if accepted)

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

IN EVENT OF EMERGENCY

Whom should we contact? _____

Relation : _____

Home Phone # : (___) _____

Work Phone #: (___) _____

Cell Phone # : (___)_____

Whom is you Medical Doctor ? _____

Medical Doctor's Phone #: (___) _____

** How did you hear about our office?

☐ Val-pak ☐ Postcards ☐ Yellow Pages

☐ Kudzu.com ☐ Website ☐ Saw our sign

☐ Someone you know? _____

NAME

DENTAL INFORMATION

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation
Are you in pain? ☐ No ☐ Yes How Long? _____

Please indicate √ any of the following problems:

☐Discomfort, clicking or popping in jaw.	☐Lost/Broken filling(s)	☐Stained teeth
☐Red, swollen or bleeding gums.	☐Locking Jaw	☐Grinding or clenching teeth
☐Ringing in Ears	☐Bad breath	☐Periodontal Treatment
☐Blisters/Sores in or around the mouth.	☐Broken/Chipped tooth	☐Snoring, Sleep Apnea
☐Food collection between teeth	☐Loose teeth	☐Sensitivity when biting
☐Sensitivity to cold	☐Sensitivity to hot	☐ Sensitivity to sweets

MEDICAL HISTORY

What medications are you taking? ☐ Nerve pills ☐ Pain Killers (including aspirin) ☐ Muscle relaxers ☐ Stimulants ☐ Blood Thinners ☐Tranquilizers ☐ Insulin ☐ Meds for Osteoporosis☐ Other(s), please list: _____UI

Have you ever taken: Bisphosphonates (ex. Aredia/ Fosamax) ☐ Yes ☐ No Phen-fen/Redux ☐ Yes ☐ No

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack/Stroke	**Y N Thyroid Problems**	**Y N Cancer/Tumors**	**Y N Cosmetic Surgery**
Y N Heart Surg./Pacemaker	**Y N Kidney Problems**	**Y N Shingles**	**Y N Xray or Colbalt Treatment**
Y N Heart Murmur	**Y N Liver Problems**	**Y N Hepatitis**	**Y N Chemotherapy**
Y N Rheumatic Fever	**Y N Respiratory Problems**	**Y N HIV+/AIDS/ARC**	**Y N Asthma**
Y N Mitral Valve Prolapse	**Y N Sinus Problems**	**Y N Arthritis/ Rheumatism**	**Y N Difficulty Breathing**
Y N Artificial Valves	**Y N Stomach Problems/Ulcers**	**Y N Artificial Bones/Joints**	**Y N Diabetes/Hypoglycemia**
Y N Heart Disease	**Y N Psychiatric Problems**	**Y N Emphysema**	**Y N Leukemia**
Y N Congenital Heart Defect	**Y N Venereal Disease**	**Y N Fainting/Seizures/Epilepsy**	**Y N Anemia**
Y N Chest Pains	**YN Alcohol/Drug Abuse**	**Y N Severe/Frequent Headaches**	**Y N High/Low Blood Pressure**
Y N Scarlett Fever	**YN Tuberculosis TB**	**Y N Frequent Neck Pain**	**Y N Bleeding Problems**
Y N Nervousness	**Y N Jaw Problems TMJ/TMD**	**YN Back Problems**	**Y N Glaucoma**

Please list any other surgeries or medical conditions you have or ever had:_____
_____

Are you allergic to any of the following? ☐ Latex ☐ Penicillin/Amoxicillin ☐ Tetracycline ☐Aspirin ☐Sulfa ☐ Clindamycin ☐Dental Anesthetics ☐Foods: _____ ☐ Others: _____

Do you use tobacco? ☐ No ☐ Yes/How used? _____ How much? _____ How Long? _____
Please rate your general health from 1-10: _____ Do you wear contact lenses? ☐ Yes ☐ No
For women: Are you taking Birth Control pills? ☐ Yes ☐ No How many children have you had? _____
Are you Pregnant? ☐No ☐ Yes/How long? _____ Are you nursing? ☐ Yes ☐ No

- We invite you to discuss with us any questions regarding our services. The best Dental Health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____Date ___/___/___