

1. About You

Today's Date: ___/___/___

Patient Name: (Last) _____ (First) _____ (MI) _____

What you prefer to be called: _____

Birthdate: ___/___/___ Age: _____ SS#: _____

Mailing Address: _____ (City, State, Zip) _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ How do you prefer to be contacted? _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____ (City, State, Zip) _____

Occupation: _____ Status: Minor Single Married Divorced Separated Widowed

Spouse's Name: _____ Do you have children? Yes No How Many? _____

2. Insurance Info

Primary Dental Insurance
Company Name: _____

Address: _____ (City, State, Zip) _____

Phone #: _____ Insured's ID#: _____

Group # (Plan, Local, or Policy #) _____

Insured's Name: _____ Relation: _____

Date of Birth: ___/___/___ Insured's Employer: _____

Secondary Dental Insurance
Company Name: _____

Address: _____ (City, State, Zip) _____

Phone #: _____ Insured's ID#: _____

Group # (Plan, Local, or Policy #) _____

Insured's Name: _____ Relation: _____

Date of Birth: ___/___/___ Insured's Employer: _____

3. Account Info

Person ultimately responsible for account

Name: _____ Relation: _____

Billing Address: _____ (City, State, Zip) _____

SS#: _____ Drivers License #: _____ Work Phone #: _____

Payment Method: Cash Check Credit Card #: _____ exp: ___/___

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

4. In Event of Emergency

Whom should we contact? _____

Relation: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Who is your medical doctor? _____

Medical Doctor's Phone #: _____

please continue on back..... ▶

5. Dental History

Reason for today's visit: _____

Date of last dental visit: ____/____/____ Date of last dental Xrays: ____/____/____

Former Dentist: _____

Address: _____

Check (✓) if you have had any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to heat |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

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

6. Medical History

Physician's Name: _____

Date of last visit: ____/____/____

Have you ever had any serious illnesses or operations? Yes No If yes, describe: _____

(Women) are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check (✓) if you have had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough Up Blood | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |

Medications: List medications you are currently taking and the correlating diagnosis:

Allergies:

7. Authorization/Release

• 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 of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expense 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

Adult Patient Parent or Guardian Spouse