WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 ABOUT YOU

Today's Date: _____

E-Mail Address: _____

Name: _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called: _____ ☐ Male ☐ Female

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

Home Address: _____
Apt/Condo #

_____
City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (____)_____ Pager / Cell #: _____

Wk #: (____)_____ Ext: ____ DL #: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

2 SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Wk #: (____)_____ Ext: ____ SS #: _____

Birthdate: ___/___/___ DL #: _____

Person Responsible for Account: _____

Wk #: (____)_____ Ext: ____ Hm #: (____) _____

Billing Address: _____

Relationship: _____ SS #: _____

Employer: _____ DL #: _____

3 INSURANCE

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

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

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

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

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Neighbor or Relative not living with you.

His / Her Name: _____ Relation: _____

Wk #: (____)_____ Hm #: (____) _____

Address: _____

_____
City State Zip

4 MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: (____)_____ Date of last visit: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

CONTINUED ON BACK

4 MEDICAL HISTORY CONTINUED

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / over-the-counter or herbal supplemental drugs? ☐ Yes ☐ No

Please list each one: _____

_____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you ever taken Phen-Fen? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems

Y	N	Abnormal Bleeding	Y	N	Herpes / Fever Blisters
Y	N	Alcohol / Drug Abuse	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	HIV+ / AIDS
Y	N	Arthritis	Y	N	Hospitalized for Any Reason
Y	N	Artificial Bones / Joints / Valves	Y	N	Kidney Problems
Y	N	Asthma	Y	N	Liver Disease
Y	N	Blood Transfusion	Y	N	Low Blood Pressure
Y	N	Cancer /Chemotherapy	Y	N	Lupus
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Osteoporosis / Paget's Disease
Y	N	Diabetes	Y	N	Pacemaker
Y	N	Difficulty Breathing	Y	N	Psychiatric Problems
Y	N	Emphysema	Y	N	Radiation Treatment
Y	N	Epilepsy	Y	N	Rheumatic / Scarlet Fever
Y	N	Fainting Spells	Y	N	Seizures
Y	N	Frequent Headaches	Y	N	Shingles
Y	N	Glaucoma	Y	N	Sickle Cell Disease / Traits
Y	N	Hay Fever	Y	N	Sinus Problems
Y	N	Heart Attack	Y	N	Stroke
Y	N	Heart Murmur	Y	N	Thyroid Problems
Y	N	Heart Surgery	Y	N	Tuberculosis (TB)
Y	N	Hemophilia	Y	N	Ulcers
Y	N	Hepatitis	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Codeine	Y	N	Latex	Y	N	Other
Y	N	Dental Anesthetics	Y	N	Penicillin			

Please list any other drugs/materials that you are allergic to: _____

_____

5 DENTAL HISTORY

Why have you come to the dentist today? _____

_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Y ☐ N Do your gums ever bleed? ☐ Y ☐ N

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

How long do you use a toothbrush before replacing it? _____

Are your teeth sensitive to heat, cold, or anything else? _____

Have you lost any teeth? ☐ Yes ☐ No If yes, why? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____

Signature Date

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____

Signature Date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

_____

MEDICAL HISTORY UPDATE

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date

Medical Information / History

Do you smoke or use tobacco? **Yes / No** Have you had metal rods or implants? **Yes / No**

Are you currently taking any prescriptions or over the counter or herbal supplemental drugs?

_____

For women: Are you using a prescribed method of birth control? **Yes / No**

Are you pregnant? **Yes / No** Are you nursing? **Yes / No**

Please list any serious medical condition(s) that you have ever had:

_____

Are you allergic to any of the following? PLEASE CIRCLE YES OR NO TO THE FOLLOWING

(Y / N) Aspirin (**Y / N**) Erythromycin (**Y / N**)Tetracycline **(Y / N)** Codeine

(**Y / N**) Latex (**Y / N**) Amoxicillin (**Y / N**) Dental Anesthetics (**Y / N**) Penicillin

(**Y / N**) OTHER - **Please list any other drug / materials that you are allergic to:**

_____

PLEASE CIRCLE YES OR NO TO THE FOLLOWING		
Y / N Abnormal Bleeding	**Y / N** Difficulty Bleeding	**Y / N** HIV/AIDS
Y / N Alcohol / Drug Abuse Any Reason	**Y / N** Emphysema	**Y / N** Hospitalized For
Y / N Anemia	**Y / N** Epilepsy	**Y / N** Kidney Problems
Y / N Arthritis	**Y / N** Fainting Spells	**Y / N** Liver Disease
Y / N Artificial Bones/Joints/Valves	**Y / N** Glaucoma	**Y / N** Low Blood Pressure
Y / N Asthma	**Y / N** Anxiety / Depression	**Y / N** Hay Fever
Y / N Blood Transfusion	**Y / N** Heart Attack	**Y / N** Pacemaker
Y / N Cancer/Chemotherapy	**Y / N** Heart Murmur	**Y / N** Psychiatric Care
Y / N Colitis	**Y / N** Heart Surgery	**Y / N** Radiation Treatment
Y / N Heart Defect	**Y / N** Seizures	**Y / N** Lupus
Y / N Diabetes	**Y / N** Hepatitis	**Y / N** Shingles
Y / N Herpes/Fever Blisters	**Y / N** High Blood Pressure	**Y / N** Sinus Problems
Y/ N Stroke	**Y / N** Thyroid Problems	**Y / N** Ulcers

Please List any other serious medical conditions that you have ever had below:

Patient Questionnaire

- In order for us to provide you with exceptional quality of care, we would like to get to know you a little better. When considering having treatment done, which of these would be of concern to you?

  Fear
  Time
  Budget
  No Sense of Urgency
  No Trust

- As providers, all of the following are important to us, but which one is the most important value to you?

  Function-Improved mobility, as in chewing
  Comfort- not wanting to be in pain when you leave the office
  Cosmetic- want to enhance their looks, all about esthetics
  Longevity- have long lasting results

- What is the most important quality for you in a relationship with a Doctor?

Patient Consent

Because of HIPAA Federal regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. We are allowed to release this information to your insurance company or as necessary to get paid for our services. You can have access to your records by simply asking.

By agreeing with this consent form, you permit the release of any information to or from your dental practitioner as may be required.

You certify that you, and/or your dependent(s), have insurance coverage as submitted on the following registration form and assign directly to your dental practitioner all insurance benefits, if any, otherwise payable to you for services rendered. You understand that you are financially responsible for all charges whether or not paid by insurance. You authorize the use of your signature on all insurance submissions. Your dental practitioner may use your health care information and may disclose such information to your Insurance Company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services.

_____ _____

Patient Signature Date

Our Patient Cancellation Policy

To our patients:

We would like to take this opportunity to thank you for coming into our office. We will do the very best we can to try and schedule your appointments in a timely manner. We do realize that everyone has a very busy schedule and sometimes it may become necessary for you to cancel an appointment. If the need to cancel does arise, we ask only that you give us at least 24 hours notice. With less than 24 hours notice, we will try to fill your space, but if we are unable to, we will need to bill you for lost time.

Please note that this policy does not apply to an emergency situation or illness.

Thank you for your cooperation.

I have read the above and understand that if I cancel my appointment I must give 24 hours notice. I will be billed for the lost time if the staff is unable to fill my space.

_____ _____

FULL NAME PRINTED *DATE*

_____

FULL NAME SIGNATURE

In an effort to keep our records fully updated please take a moment to update any information that may have changed to date:

Home # *Work # -* *Cell #-*

Home Address:

Insurance Carrier Information: