

# 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.

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## 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: \_\_\_\_\_

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## SPOUSE INFORMATION

His / Her Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ SS #: \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_ DL #: \_\_\_\_\_

Person Responsible for Account: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

Billing Address: \_\_\_\_\_

Relationship: \_\_\_\_\_ SS #: \_\_\_\_\_

Employer: \_\_\_\_\_ DL #: \_\_\_\_\_

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## 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

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## 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

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**

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

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

**Are you allergic to any of the following?**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin            | <input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin | <input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline |
| <input type="checkbox"/> Y <input type="checkbox"/> N Codeine            | <input type="checkbox"/> Y <input type="checkbox"/> N Latex        | <input type="checkbox"/> Y <input type="checkbox"/> N Other        |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin   |  |

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

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 \_\_\_\_\_

## 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.

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Patient Signature

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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:*