PATIENT INFORMATION

Patient Contact

NAME _____ Social Security No: _____

Home (Street) Address _____ City _____

State _____ Zip Code _____ DATE OF BIRTH _____

Home Phone Number _____ Cell Phone Number _____

I would like to be contacted via email for dental appointment reminders? Y [ ] N [ ]

E-Mail Address _____

Employment

Employer _____ Position _____

Address _____ Work Phone No: _____

Marital Status

Single [ ] Married [ ] Widow [ ]

Name of Your Spouse/Partner _____ Phone No: _____

Nearest relative not living with you _____ Phone No: _____

Relationship to Patient _____

Insurance Coverage Information

Subscriber's Name _____ Social Security No: _____

Subscriber's Date of Birth _____ Relationship to Patient _____

Dental Insurance Company _____ Phone Number_____

Any Other Dental Insurance _____Phone Number_____

Financial Responsibility

I understand I am fully responsible for all costs of dental treatment regardless of insurance coverage. I understand that payment is expected at the time of service unless prior financial arrangements have been made. In order to accept insurance as form of payment, all insurance payments must be assigned directly to the dentist. Any treatment not paid by the insurance company is due in full. I understand I will receive a statement for any payment due after insurance is submitted and paid. Upon receipt of the statement, I will pay promptly by the due date. I understand I am responsible for any fees associated with collecting payment.

Signature_____Date_____

How do you intend to pay for services not covered by dental insurance? (circle all that apply)

Cash Check Credit Card Care Credit Payment Plan

HEALTH HISTORY

Name: _____ **Date:** _____

Do you have any dental complaints at the present time?

_____

_____

Do you like your smile? Y [ ] N [ ]

Are you interested in a free cosmetic consultation? Y [ ] N [ ]

Medical Health History

Are you in general good health at this time? Y [ ] N [ ]

Are you pregnant or nursing? Y [ ] N [ ]

Has any physician ever informed you that you have: (Please check all that apply)

- ☐ Heart Valve Problem
- ☐ High Blood Pressure
- ☐ Respiratory Disease
- ☐ Stomach/Intestinal Issues
- ☐ Diabetes
- ☐ Rheumatism or Arthritis
- ☐ Tumors or Growths
- ☐ Rheumatic Fever
- ☐ Blood Disease
- ☐ Liver Disease
- ☐ Any Kidney Disease
- ☐ Joint Replacement - Hip / Knee / Other
- ☐ Hepatitis
- ☐ Yellow Jaundice
- ☐ HIV/AIDS

Have you had any major operations? Y [ ] N [ ] If yes, please list.

_____

_____

Are you currently taking any medications, vitamins or supplements? Y [ ] N [ ] If so, please list.

_____ _____

_____ _____

_____ _____

_____ _____

Allergies

Do you have any drug allergies or reactions , including penicillin? Y [ ] N [ ] If so, please list.

_____

Are you allergic to or have had any reactions to dental anesthetics such as Novocain? Y [ ] N [ ]

Are you allergic to or have had any reactions to materials such as Latex? Y [ ] N [ ] If so, please list.

_____

Dental Health Have you had or do you currently have any of the following? (Please check all that apply)

- Inflamed areas in or around your mouth ☐
- Do you clench or grind your teeth? ☐
- Teeth Sensitive to Hot or Cold ☐
- Pain in or near your ears? ☐
- Any difficult extractions in the past? ☐
- Do your gums bleed after brushing? ☐
- Any wounds that have healed slowly? ☐
- Sore Teeth or gums ☐
- Painful areas in the mouth ☐
- Any growth or sore spots in your mouth? ☐
- Prolonged bleeding following extractions in the past? ☐
- Do you have bad breath or a bad taste in your mouth ☐

Have you ever been shown the correct method of how to brush and floss? Y [ ] N [ ]

_____

For Office Use Only: Review and Update Medical/Dental Health History (Staff Initial and Date)

Update _____ Update_____ Update_____