Family Dental Group

Patient Information

Patient Name:_____ Date:_____
Last First MI

Male __ Female __ Married __ Single__ Child__ Other__

SSN: _____ DOB: _____ Age: _____

Phone (Home) _____ Work:_____Ext:_____ Cell Phone:_____

Address:_____
Street Apartment #

_____
City State Zip Code

Occupation: _____ Employer:_____

Emergency Contact: _____ Phone Number: _____ Relation: _____

Primary Language:_____ Secondary Language: _____

Whom may we thank for referring you to our practice? _____

Dental Insurance Information

Primary

Insurance Plan Name: _____

Name of Insured:_____ Name of Policy Holder: _____

Insured's Birth Date: _____ ID#: _____ SSN: _____

Patients relationship to insured: Self __ Spouse__ Child__ Other _____

Secondary

Insurance Plan Name: _____

Name of Insured:_____ Name of Policy Holder: _____

Insured's Birth Date: _____ ID#: _____ SSN: _____

Patients relationship to insured: Self __ Spouse__ Child__ Other _____

Please Read

1. Any dental treatment performed must be paid at the time services are rendered unless payment arrangements are made.
2. Patients who carry dental insurance are responsible for payment of all dental services not covered by the insurance including: **Any deductible, co-payment, or fee not covered by your insurance company(s) will be billed to you, and you agree that you are personally responsible for any remaining balance.**
3. Some insurance only cover the **alternative treatment**: amalgams instead of white/composite fillings, regular instead of deep scaling, and partial dentures instead of bridges. In these cases, you will be billed for the difference which is the recommended treatment plan you chose.
4. Due to constantly changing insurance limitations, we are only able to **ESTIMATE** your insurance coverage.
5. If sent to collections, the patient or account holder will be subject to an additional 30% TO 50% of the outstanding balance.
6. I authorize the doctors of Family Dental Group to perform any necessary dental work on my teeth.
7. Cancellations within 24 hour notice and no show are subject to a fee.

_____ _____

Signature of patient, parent, guardian, responsible party Relationship to Patient

Family Dental Group

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____ Do you smoke? _____

Are you allergic to? Please circle yes or no:

Y N	Aspirin	Y N	Penicillin
Y N	Latex	Y N	Codeine
Y N	Anesthetic	Y N	Other: _____

Have you ever had any of the following? Please circle yes or no:

Y N	Anemia	Y N	Growths	Y N	Respiratory Problems
Y N	Arthritis	Y N	Head Injuries	Y N	Rheumatic Fever
Y N	Artificial Heart Valve	Y N	Heart Disease	Y N	Rheumatism
Y N	Asthma	Y N	Heart Murmur	Y N	Stomach Problems
Y N	Blood Disease	Y N	Hepatitis	Y N	Stroke
Y N	Blood Thinner Medication	Y N	HIV	Y N	Thyroid Problems
Y N	Blood Transfusion	Y N	Injury to face or jaw	Y N	Tuberculosis
Y N	Cancer	Y N	Jaw popping or clicking	Y N	Tumors
Y N	Diabetes	Y N	Kidney Disease	Y N	Ulcers
Y N	Dizziness	Y N	Liver Disease	Y N	Low/High Blood Pressure
Y N	Emotional Problems	Y N	Pacemaker	Y N	Pregnant Due Date:_____
Y N	Epilepsy	Y N	Nursing	Y N	Radiation Treatment
Y N	Excessive Bleeding	Y N	Artificial Joints/Plates	Y N	Other: _____

Are you under any medications or have you been under any medications in the past year? _____

Please list them: _____

Have you ever had any complications following dental treatment? Y N

If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? Y N

If yes, please explain: _____

Are you now under the care of a physician? Y N

If yes, please explain: _____

Name of Physician: _____

Phone and Address: _____

Do you have any health problems that need further clarification? Y N

If yes, please explain: _____

Dental History Review

Are you happy with your smile? _____

Are you currently in pain? _____

Are you interested in knowing the options available for a more beautiful smile? _____

Is there anything else you would like us to know? _____

_____