PATIENT INFORMATION

CONFIDENTIAL

(PLEASE PRINT)

DATE ______________

NAME ______________________________ BIRTHDATE ______________ SS # ______________

ADDRESS ______________________________ CITY ______________ STATE ________ ZIP ________

HOME PHONE ______________ CELL PHONE ______________ EMAIL ______________

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

SPOUSE OR PARENT'S NAME ______________ EMPLOYER ______________ WORK PHONE ______________

WHOM MAY WE THANK FOR REFERRING YOU? ______________________________

PERSON TO CONTACT IN CASE OF AN EMERGENCY ______________________________ PHONE ______________

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT ______________ RELATIONSHIP TO PATIENT ________

ADDRESS ______________________________ HOME PHONE ______________

EMAIL ______________________________ CELL PHONE ______________

EMPLOYER ______________________________ WORK PHONE ______________

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED ______________________________ RELATIONSHIP TO PATIENT ________

BIRTHDATE ______________ SS#/SIN ______________ DATE EMPLOYED ______________

NAME OF EMPLOYER ______________________________ WORK PHONE ______________

ADDRESS OF EMPLOYER ______________________________ CITY ______________ STATE ________ ZIP ________

INSURANCE COMPANY ______________________________ GROUP# ______________ MEMBER ID ______________

INS. CO. ADDRESS ______________________________ CITY ______________ STATE ________ ZIP ________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED ______________________________ RELATIONSHIP TO PATIENT ________

BIRTHDATE ______________ SS#/SIN ______________ DATE EMPLOYED ______________

NAME OF EMPLOYER ______________________________ WORK PHONE ______________

ADDRESS OF EMPLOYER ______________________________ CITY ______________ STATE ________ ZIP ________

INSURANCE COMPANY ______________________________ GROUP# ______________ MEMBER ID ______________

INS. CO. ADDRESS ______________________________ CITY ______________ STATE ________ ZIP ________

SIGNATURE

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X ______________________________ ______________

PATIENT, PARENT OR GUARDIAN DATE

PATIENT MEDICAL HISTORY

PHYSICIAN ______________________ OFFICE PHONE ______________ DATE OF LAST EXAM ______________

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU EVER TAKEN BONE LOSS PREVENTION DRUGS SUCH AS FOSOMAX, ACTONEL, BONIVIA OR OTHER BISPHOSPHONATES?	☐	☐
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? IF YES, WHAT MEDICATION(S) ARE YOU TAKING?	☐	☐

NAME: ______________________

FOR WHAT CONDITION: ______________________

NAME: ______________________

FOR WHAT CONDITION: ______________________

NAME: ______________________

FOR WHAT CONDITION: ______________________

NAME: ______________________

FOR WHAT CONDITION: ______________________

	YES	NO
4. HAVE YOU HAD ANY MAJOR SURGERY WITHIN THE LAST YEAR?	☐	☐

5. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

	YES	NO		YES	NO
LOCAL ANESTHETICS (EG. NOVOCAINE)	☐	☐	LATEX	☐	☐
PENICILLIN OR OTHER ANTIBIOTICS	☐	☐	ASPIRIN	☐	☐
OTHER ______________	☐	☐			

6. WOMEN ONLY:

	YES	NO
A. ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
B. ARE YOU NURSING?	☐	☐
C. ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

COMMENTS

____

____

____

____

____

SIGNATURE OF DENTIST DATE

7. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	HIGH BLOOD PRESSURE	☐	☐	RHEUMATIC FEVER	☐	☐	DIABETES
☐	☐	HEART DISEASE	☐	☐	ANGINA	☐	☐	HEPATITIS/JAUNDICE
☐	☐	CARDIAC PACEMAKER	☐	☐	RADIATION THERAPY	☐	☐	ASTHMA
☐	☐	CARDIAC DEFIBRILLATOR	☐	☐	AIDS OR HIV	☐	☐	CANCER
☐	☐	HEART MURMUR	☐	☐	FAINTING/SEIZURES	☐	☐	JOINT REPLACEMENT
☐	☐	HEART VALVE REPLACEMENT	☐	☐	EPILEPSY/CONVULSIONS	☐	☐	OTHER

PATIENT DENTAL HISTORY

	YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐	☐
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	☐	☐
3. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
A. CLICKING?	☐	☐
B. PAIN (JOINT, EAR, SIDE OF FACE)?	☐	☐
C. DIFFICULTY IN OPENING OR CLOSING?	☐	☐
D. DIFFICULTY IN CHEWING?	☐	☐
4. DO YOU HAVE FREQUENT HEADACHES?	☐	☐
5. DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
6. WOULD YOU LIKE YOUR TEETH WHITER?	☐	☐
7. WOULD YOU LIKE YOUR TEETH STRAIGHTER?	☐	☐

Cancellation Policy

Patients are required to inform the office at least 24 hours' notice prior to cancelling or rescheduling an appointment. Failure to do so will result in a $65 cancellation fee.

SIGNATURE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

X ______________________ ______________

PATIENT, PARENT OR GUARDIAN DATE