PLEASE COMPLETE AND RETURN TO FRONT DESK

| Name: | Last | First | Middle | | |
|---|---|---|---|---|---|
| Address: | Street or P O Box | City | State | Zip Code | Phone Number<br>Home:<br>Work: |

| Age: Yrs. | Birth Date Mo. Day Year | Birthplace | ( ) Married<br>( ) Unmarried<br>( ) Separated | Social Security No. (If child, parent's)<br>Driver's License No. |
|---|---|---|---|---|

| Occupation | Employer | How Long Employed? | Address & Phone No. |
|---|---|---|---|
| Person Responsible for Bill<br>(If married, spouse's name) | Age | Address Relationship | Social Security No.<br>Driver's License No. |
| Occupation | Employer | How Long Employed? | Address & Phone No. |

## INSURANCE INFORMATION

Insured Person's Full Name _____ Insured's Date of Birth _____

Social Security Number _____ Relationship to Patient _____ Work Phone _____

Insurance Company Name _____ Group or Union Name _____ Group or Local Number _____

Employer's Name _____ Benefit Coordinator's Name _____ Full Address of Employer _____

## GETTING TO KNOW YOU

1. Why did you select our office?

2. Whom may we thank for referring you?

3. Is another member of your family or relative a patient in our practice?

4. Person to contact for emergency:_____

5. When was your last dental visit?_____

6. When was the last time you had complete dental X-rays taken? Physician:

7. Have you ever had any teeth removed?_____
How long have these teeth been missing?_____
Have these teeth been replaced?_____

How? ☐ Bridge ☐ Partial ☐ Denture ☐ Implants

## PAYMENT ALTERNATIVES

Please check appropriate box:

☐1. As a special service to you, we offer a cash courtesy if you pay for your entire treatment plan in full, in advance.

☐2. Cash and personal checks are accepted as your treatments are provided. (However, only cash and/or credit cards accepted by emergency and/or first time patients.)

☐3. If you have dental insurance, we want you to receive the full benefit of it. Our office staff can assist you in completing your insurance forms and verifying the coverage that your particular program provides. We accept assignment of your insurance payment; another service to you. This means that you are responsible for your deductible and the portion the insurance does not cover. Remember, however, that you are responsible for the account if the insurance company, does not honor their commitment to you and to us. Outstanding Balances will accrue interest at 1 ½ % per month.

☐4. Mastercard, Visa, and Discover.

## FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all forms of treatment, medicine, and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and his staff. I agree to pay for all services rendered by this office. If there is any attempt by this office to collect any outstanding balance, I will be responsible for any and all collection fees and attorney fees.

SIGNATURE OF RESPONSIBLE PARTY _____ RELATIONSHIP _____ DATE _____ (over)

# MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? □ YES □ NO
   If yes, for what reason?_____
2. Please provide the name, address, and telephone number of your physician.

_____

3. Are you having dental problems at this time? ---------- □ YES □ NO
4. Do your gums bleed at any time?---------- □ YES □ NO
5. Do you feel very nervous about having dental treatment?---------- □ YES □ NO
6. Have you ever had a bad experience in the dental office?---------- □ YES □ NO
7. Have you been a patient in the hospital during the past two years?---------- □ YES □ NO
8. Have you taken any medicine or drugs during the past two years?---------- □ YES □ NO
9. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications?---------- □ YES □ NO
   If yes, please list:_____
10. Have you ever had excessive bleeding requiring special treatment or regularly taking any blood thinners including aspirin?---------- □ YES □ NO
11. Have you ever been told you need to premedicate with antibiotics before you have dental treatment? (i.e., defective heart valve, replaced heart valve or any joints, any recent surgeries where synthetic materials were incorporated in body) If yes, please provide details:_____ □ YES □ NO
12. Check any of the following which you have had or have at present:

| | | |
|---|---|---|
| □ Heart Failure | □ Shortness of Breath | □ HIV Positive (AIDS) |
| □ Heart Disease or Attack | □ Emphysema | □ Hepatitis A (Infectious) |
| □ Angina Pectoris (chest pain) | □ Hepatitis B (Serum) | □ High Blood Pressure |
| □ Tuberculosis (TB) | □ Liver Disease | □ Heart Murmur |
| □ Asthma | □ Yellow Jaundice | □ Bruise Easily |
| □ Rheumatic Fever | □ Hay Fever | □ Blood Transfusion |
| □ Congenital Heart Lesions | □ Allergies or Hives | □ Drug Addiction |
| □ Scarlet Fever | □ Diabetes | □ Hemophilia |
| □ Artificial Heart Valve | □ Thyroid Disease | □ Venereal Disease (Syphilis, Gonorrhea) |
| □ Heart Pacemaker | □ X-Ray or Cobalt Treatment | □ Cold Sores or Fever Blisters |
| □ Heart Surgery | □ Chemotherapy (Cancer, Leukemia) | □ Genital Herpes |
| □ Artificial Joint | □ Arthritis | □ Epilepsy or Seizures |
| □ Anemia | □ Rheumatism | □ Fainting or Dizzy Spells |
| □ Stroke | □ Cortisone Medication | □ Nervousness |
| □ Kidney Trouble | □ Glaucoma | □ Psychiatric Treatment |
| □ Ulcers | □ Pain in Jaws Joints | □ Sickle Cell Disease |

13. List all medications you are taking at this time._____
14. Are you a smoker?---------- □ YES □ NO
15. Do you use or have you ever used recreational drugs?---------- □ YES □ NO
16. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired?---------- □ YES □ NO
17. Do your ankles swell during the day?---------- □ YES □ NO
18. Have you lost or gained more than 10 pounds in the last year?---------- □ YES □ NO
19. Do you use more than 2 pillows to sleep?---------- □ YES □ NO
20. Do you ever wake up from sleep short of breath?---------- □ YES □ NO
21. Are you on a special diet?---------- □ YES □ NO
22. Has your medical doctor ever said you have cancer or a tumor?---------- □ YES □ NO
23. Do you have any disease, condition or problem not listed? If so, please list.---------- □ YES □ NO

_____

24. How do you feel about getting and maintaining a healthy mouth? _____

_____

25. How do you feel about the appearance of your teeth? _____

_____

26. If you could change anything about your smile, what would you change? _____

_____

27. Women: Are you pregnant? □ YES □ NO If yes, what month are you due? _____
    Are you taking birth control pills?---------- □ YES □ NO

_____

Signature of Responsible Party Relationship Date

(over)