**Patient Information**

Patient Name: Date*: 05/08/2018*

Last, First MI (Preferred Name)

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:  Family Status: M/S/W/D

Social Security *#:*  Birth Date:

Phone (Home):  (Work):  Ext: Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_

Address:

Street Apartment #

City State Zip Code

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name

How would you like to be contacted? Phone, Text, Email

**Health Information**

Date of Last Dental Visit/X-rays: Reason for this visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (e.g.: pain, checkup, etc.)

**Have you ever had/ or currently have any of the following? Please check those that apply:**

|  |
| --- |
| AIDS/HIV |
| Allergies \_\_\_\_\_\_\_\_\_\_ |
| Anemia |
| Arthritis |
| Artificial Joints |
| Asthma |
| Blood Disorder/Hemophiliac |
| Blood Disease |
| Cancer |
| Diabetes |
| Dizziness |
| Epilepsy |
| Excessive Bleeding |
| Fainting |
| Glaucoma |
| Growths |
| Hay Fever |
| Head Injuries |
| Heart Disease |
| Heart Murmur |
| Hepatitis |
| High Blood Pressure |
| Jaundice |
| Kidney Disease |
| Liver Disease |
| Mental Disorders |
| Nervous Disorders |
| Pacemaker |
| Pregnancy |
| Due date:\_\_\_\_\_\_\_\_\_ |
| Birth Control Pills |
| Radiation Treatment |
| Respiratory Problems |
| Rheumatic Fever |
| Rheumatism |
| Sinus Problems |
| Stomach Problems |
| Stroke |
| Tuberculosis |
| Tumors |
| Ulcers |
| Venereal Disease |
| Codeine Allergy |
| Latex Allergy |
| Penicillin Allergy |
| OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

• Do you have Implants/Artificial Joints: ❑ Hip ❑ Knee ❑ Other Antibiotic PreMedication Needed? Y/N

• Name of Orthopedic Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Do you smoke or use tobacco. If yes, how much per day? How many years?

• Have you ever had any complications following dental treatment?  Yes  No

If yes, please explain:

• Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No

If yes, please explain:

• Are you now under the care of a physician?  Yes  No

If yes, please explain:

• List All Medications you are currently taking:

Medicine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Name of Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:

• Do you have any health problems that need further clarification?  Yes  No

If yes, please explain:

*Help Us Get to Know You*

Reasons for changing dentists: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you nervous about seeing a dentist? ❑ Yes! ❑ No If yes, please tell us why:

How often do you brush? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you floss? ❑ Yes ❑ No How often? \_\_\_\_\_\_\_\_

(please circle each)

Y N I clench or grind my teeth during the day or while sleeping. Y N My gums feel tender or swollen

Y N My gums bleed while brushing or flossing. Y N I have problems eating.

Y N I like my smile.

Y N I have had orthodontics.

Y N I prefer tooth-colored fillings.

Y N I have had a facial or jaw injury.

Y N I avoid brushing part of my mouth due to pain.

Y N I want my teeth straight.

Y N I want my teeth whiter.

What are your dental priorities?

*(e.g.: appearance, dental health, financial considerations, etc.)*

# How did you hear about us?

Whom may we thank for referring you to our practice?  Patient Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Dental Office  Coupon Connection  Newspaper  Social Media  Google  Insurance

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
**Responsible Party Information**

The following is for:  the patient's spouse  the person responsible for payment

Name:

City State Zip Code

**Employment Information**

The following is for:  the patient  the person responsible for payment

Employer Name: Occupation:

Address:

Street City, State Zip Code Phone

**Insurance Information**

***Give Us your Insurance Card & driver’s license (to copy) and we’ll call the insurance company!***

## Consent for Services

This office attempts to maintain the highest standard of cleanliness and sterilization, your observation and comments are always appreciated. In trying to keep fees as low as possible, we expect our non-insured and reduced –fee dental plan patients ***to pay for our services when rendered***. Insurance forms will be submitted for the individuals under insurance pans and **the balance is expected within 30 days**. If there are extenuating circumstances, prior arrangements can be made with the receptionist. A 1.5% interest charge will be assessed after 30 days.

All **cancellations** or No-Shows with less than a **24 hour notice** will result in a   
**cancellation fee** of $50.

I have read the above conditions of treatment and payment and agree to their content.

**X** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient:

Signature of patient, parent or guardian

**X** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient:

Signature of guarantor of payment/responsible party