Patient Information

Patient Name: _____ Date: _____
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