PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name_____
Last First MI (Preferred)

Birthdate_____ SS#_____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Work Phone_____ Wireless Phone_____ Wireless Carrier_____

Email_____

Preferred contact method [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Preferred contact method for confirmations [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Preferred contact method for recall [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Student status if dependent over 19 (for ins) [ ] Nonstudent [ ] Fulltime [ ] Parttime

How did you hear about us?

_____

(If someone referred you here, please write down their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family [ ]

Address_____

Address 2_____

City_____ State_____Zip_____

Home Phone_____

INSURANCE POLICY 1

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____Subscriber ID # _____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____Subscriber ID # _____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

Comments:

Medical History for New Patient

Last Name: \ First Name: \ Birthdate: \

Name of Medical Doctor:_____ City/State:_____

Emergency Contact_____ Phone_____ Relationship_____

List all medications that you are now taking:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING: (PLEASE CHECK BELOW)

- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Artificial Joints / Heart Valves
- ☐ Rheumatic Fever
- ☐ Prolonged Bleeding
- ☐ Anemia
- ☐ Abnormal Blood Pressure
- ☐ Ulcers
- ☐ TB or Lung Disease
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Thyroid
- ☐ Jaw Pain / Tired Jaw Muscles
- ☐ Dizziness / Loss of Balance
- ☐ Earaches
- ☐ Ear Stuffiness / Loss of Hearing
- ☐ Ringing in Ears
- ☐ Neck Pain
- ☐ Headaches / Migrains / Facial Pain
- ☐ Clenching / Grinding
- ☐ Change in bite
- ☐ Jaw Locking / Catching
- ☐ Jaw Clicking / Popping
- ☐ Snoring
- ☐ Cancer
- ☐ Epilepsy
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Asthma
- ☐ Sinus Problems
- ☐ Cough
- ☐ Arthritis
- ☐ Stroke
- ☐ Glaucoma
- ☐ Aids / Aids Related Complex
- ☐ Psychiatric Treatment

Tobacco use? If so, what kind and how much?_____

Unusual reaction to dental injections?_____

Reason for today's visit_____ Are you in pain?_____

New patients:

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old?_____

Do you have BiteWing x-rays that are less than 1 year old?_____

Name of former dentist_____ City/State_____

Date of last cleaning and exam_____

Authorization and Release

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 of the doctors and/or assistants. I authorize the dentist to release any information including diagnoses and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on my dependents.
I am aware that there will be broken appointment fee if I fail to give 24 hr. notification of a cancellation.

Signature of patient or parent if minor _____ Date_____