PATIENT INFORMATION

CONFIDENTIAL

(PLEASE PRINT)

DATE _____

NAME _____ (FIRST MI LAST) BIRTHDATE _____ HOME PHONE _____

ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

SS # _____ CELL PHONE _____

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

PATIENT'S OR PARENT/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

SPOUSE OR PARENT/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____ CITY _____ STATE/PROV. _____

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 _____

SS # _____ CELL PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____

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 _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

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

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

OFFICE PHONE _____

ARE YOU UNDER MEDICAL TREATMENT NOW Y N

ARE YOU TAKING ANY MEDICATIONS Y N
IF YES, WHAT MEDICATIONS ARE YOU TAKING _____

DO YOU USE TOBACCO Y N

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO THE FOLLOWNG

LOCAL ANESTHETICS (e.g. NOVOCAINE)	Y N	CODEINE	Y N
PENICILLIN OR OTHER ANTIBIOTICS	Y N	ASPIRIN	Y N
SULFA DRUGS	Y N	OTHER	Y N
		PLEASE LIST:	_____

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

HIGH BLOOD PRESSURE	Y N	ANGINA	Y N
HEART ATTACK	Y N	ANEMIA	Y N
RHEUMATIC FEVER	Y N	EMPHYSEMA	Y N
FAINTING/NERVOUS	Y N	CANCER	Y N
ASTHMA	Y N	ARTHRITIS	Y N
LOW BLOOD PRESSURE	Y N	JOINT REPLACEMENT/IMPLANT	Y N
EPILEPSY/SEIZURES	Y N	HEPATITIS/LIVER DISEASE	Y N
LEUKEMIA	Y N	CHEST PAINS	Y N
DIABETES	Y N	STROKE	Y N
KIDNEY DISEASES	Y N	HAY FEVER/ALLERGIES	Y N
AIDS OR HIV INFECTION	Y N	TUBERCULOSIS	Y N
THYROID PROBLEM	Y N	RADIATION THERAPY	Y N
HEART DISEASE	Y N	HERPES VIRUS	Y N
CARDIAC PACEMAKER	Y N	RESPIRATORY PROBLEMS	Y N
HEART MURMER/MVP	Y N	OTHER	Y N

_____

ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT Y N

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. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	☐	☐
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	☐	☐
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	☐
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	☐	☐
7. 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?	☐	☐

	YES	NO
8. DO YOU HAVE FREQUENT HEADACHES?	☐	☐
9. DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	☐	☐
11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	☐	☐
12. HAVE YOU HAD ANY ORTHODONTIC WORK?	☐	☐
13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	☐	☐
14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?	☐	☐
15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?	☐	☐

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist benefits otherwise payable to me. I authorize the dentist to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I agree to pay any and all collection costs involved if account becomes delinquent. I authorize the use of this signature on all insurance submissions.

I ACKNOWLEDGE THAT I HAVE READ/RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

_____ _____
PATIENT/PARENT OR GUARDIAN DATE

_____ _____
DOCTOR'S SIGNATURE DATE