Thank you for visiting our office. We want your visit to be pleasant and comfortable. Please help us by completing this form. All of this information is completely confidential.

## Patient Information

Full Patient Name ______________________________________________ Preferred Name ____________________
First Middle Initial Last

Home Address ________________________________________________ Home Phone ______________________

City ____________________________ State ________ Zip Code ___________ Work Phone ______________________

E-mail Address _______________________________________________ Cell Phone ______________________

Sex: Male Female Birth date _________________ Single – Married – Widowed – Separated – Divorced

Patient Social Security # ___________________ Patient Employer & Occupation ________________________________

Spouse's Name __________________________ Spouse's Employer & Occupation ______________________________

Emergency contact name & phone number ______________________________________________________________

How did you hear about our office? ____________________________________________________________________

## Responsible Party Information

Person Financially Responsible _______________________________________ Relation to patient _________________

Home Address ________________________________________________ Home Phone ______________________

City ____________________________ State ________ Zip Code ___________ Work Phone ______________________

Birth Date ___________ SS# ________________ Employer __________________________

## Dental Insurance Information

**Is patient covered by dental insurance? Yes / No** (if yes, please complete the following:)

Policy Holder Name ___________________________________________ Relation to patient _________________

Home Address ________________________________________________ Home Phone ______________________

City ____________________________ State ________ Zip Code ___________ Work Phone ______________________

Birth Date ___________ SS# ______________________ Employer __________________________

Insurance Company ______________________ Group # ___________________ Subscriber ID# ____________________

**Is patient covered by additional dental insurance? Yes / No** (if yes, please complete the following:)

Policy Holder Name ___________________________________________ Relation to patient _________________

Home Address ________________________________________________ Home Phone ______________________

City ____________________________ State ________ Zip Code ___________ Work Phone ______________________

Birth Date ___________ SS# ______________________ Employed by ______________________

Insurance Company ______________________ Group # ___________________ Subscriber ID# ____________________

### INSURANCE AUTHORIZATION & FINANCIAL RESPONSIBILITY AGREEMENT

I understand that I am financially responsible for all charges whether or not paid by insurance. Returned checks are subject to a $35.00 fee and balances older than 60 days may be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually). Additionally, at the discretion of our practice we may charge you $25.00 for appointments that you do not keep and for appointments that you do not cancel with 24 hour notice. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

______________________________________ ________________________________ _____________
Signature (Parent/Guardian if under age 18) Relationship (if patient is under age 18) Date

**Please complete both sides of this form**

# Medical History

**Name**______________________________

Physician's Name ______________________________ Phone __________________ Date of Last Visit__________

**Circle Yes or No (Y or N) if you have ever had any of the following:**

Y--N AIDS or HIV positive
Y--N Acid Reflux/ G.E.R.D
Y--N Arthritis, Type:________
Y--N Artificial joints
Y--N Asthma
Y--N Cancer
Y--N Chemical Dependency
Y--N Diabetes, Type:______
Y--N Eating disorder
Y--N Epilepsy
Y--N Excessive bleeding

Y--N Glaucoma
Y--N Hepatitis, Type:_______
Y--N Kidney problems
Y--N Liver problems or Jaundice
Y--N Lung or breathing problems
Y--N Sinus trouble
Y--N Smoking/chewing tobacco
Y--N Stroke
Y--N Swollen neck glands
Y--N Thyroid problems
Y--N Tuberculosis

Heart Problems
- Y--N Low blood pressure
- Y--N High blood pressure
- Y--N Pacemaker
- Y--N Artificial valves
- Y--N Infective (Bacterial) Endocarditis
- Y--N Congential heart defects
- Y--N Heart Surgeries
- Y--N Other____________________

Y--N Serious illnesses/hospitalizations
Y--N Currently under a physician's care
Y--N Antibiotics for dental treatment

Give details of the above 'Yes' items________________________________________

____________________________________________________________

____________________________________________________________

Women:
Are you pregnant?____________ Due when?___________
Are you nursing?_____________

**ALLERGIES** Circle if you are allergic to:
Aspirin – Codeine – Latex – Local anesthetic – Penicillin – Sulfa
Other allergies:____________________________________

**MEDICATIONS**: Please list medications you are currently taking and why:

____________________________________________________________

____________________________________________________________

# Dental History (New Patients Only)

**Circle if you have ever had any of the following:**

Bad breath problem
Frequent headaches, neck aches
TMJ, jaw joint pain or treatment
Gum disease treatment
Canker sores in mouth
Cold sores on outer lips
Dental anesthetic problems
Orthodontics (braces)
Full dentures / Partial dentures
Biteguard / Nightguard
Oral surgery
Excessive gag reflex
Fear of dental care

**Circle if you currently have any of the following:**

Pain
Toothache
Vague ache
Swelling

Sensitivity to:
- heat – cold – biting
- sweets – pressure

Broken tooth or filling
Loose tooth

Dry mouth
Mouth breathing
Sores or growths in mouth
Bleeding gums
Food packing between teeth

Clicking or popping jaw
Clenching or grinding of teeth
Tired, sore or painful jaw joint
Pain around ear
Other:____________________

Give details and location of the above circled items__________________________________

____________________________________________________________

How often do you brush?_______ floss?________ What type toothbrush do you use? Ultrasoft – Soft – Medium – Hard – Electric

Would you like improve the appearance of your smile?___________ How?______________________________________

Reason for today's visit ___________________________________________________

Former Dentist _________________________________ City/State ________________ Phone____________________

Date and reason of last dental visit ________________________________ Date of last dental X-rays ________________

What have you liked about any dental office you've been to?________________________ Least?________________________

**TREATMENT AUTHORIZATION**

I have reviewed the information on both sided of this form and it is accurate to the best of my knowledge. I authorize and give consent for the dentist and/or team of this office to perform dental services as agreed between doctor and patient and/or guardian, including the use of local anesthetic and other medication as indicated.

_____________________________ ___________________________ ____________

Signature (Parent/Guardian if under age 18) Relationship (if patient is under age 18) Date