Patient Information

Date:_____

Name_____ Nickname_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell_____ Work Phone_____

Email_____ Employer_____

Soc. Sec. #_____ Birth Date_____ Age_____ Sex ❑ M ❑ F

Person to Notify In Emergency (Name and Number)_____

Referred By: ❑ Family/Friend:_____ ❑ Google ❑ Insurance ❑ Other:_____

Preferred Pharmacy (name and number):_____

Primary Insurance

Dental Insurance Company:_____ Insurance Phone#_____

Policy Holder Name_____ Date of Birth_____

Primary Member ID/SS#:_____ Policy Holder Employer_____

Medical History

Physician's Name_____ Phone Number_____

Have you had any recent serious illnesses or operations? ❑ Y ❑ N if yes, describe_____

Are you currently under physician care? ❑ Y ❑ N if yes, describe_____

Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drug? ❑ Y ❑ N

Are you aware of any allergy or adverse reaction to any substance or medication? ❑ Y ❑ N

If yes, please specify_____

*Women, are you: (Check all that apply) ❑ Pregnant ❑ Trying to get pregnant ❑ Taking birth control ❑ Nursing

Indicate which of the following you have had, or have at present. Check "Y" for Yes or "N" for No to each item

Heart (Surgery, Disease, Attack)	❑ Yes ❑ No	Kidney Trouble	❑ Yes ❑ No	AIDS/HIV Positive	❑ Yes ❑ No
Chest Pain	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No	Premed for Dental Work	❑ Yes ❑ No
Congenital Heart Disease	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Blood Transfusion	❑ Yes ❑ No
Heart Murmur	❑ Yes ❑ No	Thyroid Problems	❑ Yes ❑ No	Hemophilia	❑ Yes ❑ No
High/Low Blood Pressure	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No	Bruise Easily	❑ Yes ❑ No
Mitral Valve Prolapse	❑ Yes ❑ No	Sickle Cell Disease	❑ Yes ❑ No	Cold Sores/Fever Blisters/ Ulcers	❑ Yes ❑ No
Artificial Heart Valve /Pacemaker	❑ Yes ❑ No	Emphysema	❑ Yes ❑ No	Neurological Disorders	❑ Yes ❑ No
Rheumatic Fever	❑ Yes ❑ No	Chronic Cough	❑ Yes ❑ No	Epilepsy or Seizures	❑ Yes ❑ No
Arthritis/Rheumatism	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No	Fainting or Dizzy Spells	❑ Yes ❑ No
Cortisone Medicine	❑ Yes ❑ No	Asthma	❑ Yes ❑ No	Nervous/Anxious	❑ Yes ❑ No
Swollen Ankles	❑ Yes ❑ No	Hay Fever/Allergy/Hives	❑ Yes ❑ No	Psychiatric/Psychological Care	❑ Yes ❑ No
Stroke	❑ Yes ❑ No	Latex Sensitivity	❑ Yes ❑ No		
Diet (Special/Restricted)	❑ Yes ❑ No	Sinus Trouble	❑ Yes ❑ No		
Artificial Joints/Implants (Hip, Knee, Cosmetic Enhancements, etc.)	❑ Yes ❑ No	Radiation Therapy	❑ Yes ❑ No		
		Chemotherapy	❑ Yes ❑ No		
		Tumors	❑ Yes ❑ No		
		Hepatitis (A,B,C)	❑ A ❑ B ❑ C		

Have you ever had any serious illness not listed above?_____

Please list current medications:_____

_____

Dental History

Patient Name:_____

How would you rate the condition of your mouth? Excellent Good Fair Poor

I routinely see the dentist every: 3 months 4 months 6 months 12 months Not routinely

What are your immediate dental concerns?_____

Please answer the following

1. Are you fearful of dental treatment? ❑ Yes ❑ No How fearful on a scale of 1 (least) to 10 (most)?_____
2. Have you had complications from past dental treatment? ❑ Yes ❑ No
3. Have you ever had trouble getting numb or had any reactions to local anesthetic? ❑ Yes ❑ No
4. Did you ever have braces or orthodontic treatment? ❑ Yes ❑ No
5. Is there anything about the appearance of your teeth you would like to change? ❑ Yes ❑ No
6. Have you ever whitened (bleached) your teeth? ❑ Yes ❑ No
7. Have you felt uncomfortable or self-conscious about the appearance of your teeth? ❑ Yes ❑ No
8. Do you have problems with your jaw joint? (pain, sounds, limited opening, lock popping) ❑ Yes ❑ No
9. Have your teeth changed in the last 5 years, becoming shorter, thinner or worn? ❑ Yes ❑ No
10. Do you chew ice, bite your nails, use your teeth to hold objects or have any other oral habits? ❑ Yes ❑ No
11. Do you wear or have you ever worn a bite appliance?(night guard) ❑ Yes ❑ No
12. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part? ❑ Yes ❑ No
13. Do you frequently get food caught between any teeth? ❑ Yes ❑ No
14. Do your gums bleed or are they painful when brushing or flossing? ❑ Yes ❑ No
15. Have you ever been treated for gum disease or been told you have bone loss around your mouth? ❑ Yes ❑ No

Office Policies

It is our sincere intention to provide the best dental care available at the most reasonable fees. Also, we hope that by providing you with the following information, no misunderstandings will arise as we proceed with your treatment.

Treatment plans with your estimated out of pocket will be provided before the start of any treatment. We try to carefully plan all treatments, but during the course of treatment, additional, alternative or more costly treatment may become necessary. We will, of course inform you of such an event before continuing.

Payment is due at time services are rendered; we accept cash, personal checks, Discover, MasterCard, Visa and American Express. For treatment $1000 or greater, financing is available through Care Credit, with approved credit.

We understand that our patients rely on their dental insurance benefits to help defray the costs of dental services. We are happy to assist you in filling your claim with your dental insurance company. Please remember that the contract itemizing your dental benefits is between you, your employer, and your insurance carrier.

Appointments broken or cancelled without 48 hour notification, or repeated cancellations, will incur cancellation fees. I am aware that if proper notice is not given I will be charged $25 per half hour of appointment time scheduled.

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.
I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____

Signature (patient or responsible party) Date

_____

Doctor Signature Date