Welcome to our Practice!

Today's Date _____
Name of Patient _____ Preferred Name _____ Sex: M____F_____
Birthdate _____Age _____ SSN _____Marital Status _____
Mailing Address _____City_____State_____Zip _____
Home Phone _____Cell _____E-mail address _____

Please cross-out the ways we may NOT contact you: e-mail, cell phone, work phone, home phone.
May we text you? YES NO

Patient Employed by _____Occupation_____Work Phone _____
Name of Spouse, Parent, or Responsible Party(If patient is under 18, name of parents) _____
Address of Spouse, Parent, or Responsible Party _____DOB_____SSN_____
In case of emergency, who should be notified: _____Cell_____Relationship _____
Purpose of today's appointment _____

• • • • • • • • • • *Insurance Information* • • • • • • • • • •

Do you have dental insurance? Yes___No___ If yes, name of company
Name of policy holder _____Policy holder's SSN _____ Birthdate
Do you have secondary dental insurance? Yes___No___ If yes, name of company
Name of policy holder _____Policy Holder's SSN _____ Birthdate_____
Policy holder's employer _____ Phone _____

Please take your insurance card and driver's license to our front desk for duplication and verification.

• • • • • • • • • • *Medical History* • • • • • • • • • •

List medications to which you have reaction or are allergic.
_____
_____
List medications you are currently taking.
_____
_____

Have you ever had any of the following? Please circle "yes " or "no" for each condition and write details when response is "yes".

No ADD or ADHD Yes, Details _____
No AIDS/HIV Yes, Details _____
No Alzheimer's/dementia Yes, Details _____
No Arthritis Yes, Details_____
No Autism Yes, Details_____
No Blood Disorders Yes, Details_____
No Blood Pressure Problems Yes, Details _____
No Blood-thinning Medication Yes, Name _____
No Blood Transfusion Yes, Details _____
No Cancer Yes, Details_____
No Chemotherapy Yes, Details _____
No Diabetes Yes, Type _____
No Drug Abuse Yes, Details _____
No Dry Mouth Yes, Details_____
No Epilepsy Yes, Details_____
No Gastric Ulcers Yes, Details_____
No Glaucoma Yes, Details_____
No Heart Murmur Yes, Details_____
No Heart Valve Replacement Yes, Details_____
No Hepatitis/Liver Disease Yes, Details_____
_____

No Heart Disease Yes, Details_____
No Hemophilia Yes, Details_____
No Heart Surgery Yes, Details _____
No Hepatitis Yes, Details _____
No Herpes/Fever Blisters Yes, Details_____
No Joint Replacement Yes, Details_____
No Kidney Disease Yes, Details_____
No Latex Allergy Yes, Details_____
No Mitral Valve Prolapse Yes, Details_____
No Osteoporosis Yes, Details_____
No Pacemaker Yes, Details _____
No Parkinson's Disease Yes, Details _____
No Pregnant Yes, Due Date _____
No Radiation Treatment Yes,
No Blood-thinning Medication Yes, Type
No Rheumatic Fever Yes, Details_____

PLEASE CONTINUE TO THE REVERSE SIDE

Name of Physician: _____Phone_____

What pharmacy do you prefer? _____Location_____Phone_____

Other medical conditions not indicated: _____

Have you ever had problems with local anesthesia (numbing your teeth)? Yes_____ No_____
Details_____
Have you had serious problems associated with dental treatment? Yes_____ No_____
Details_____
Please indicate special needs: Wheelchair? Neck pillow? Back pillow? Blanket? Walking assistance? Other?

PLEASE ANSWER : How or from whom did you heard about our practice?

Please inform us of the persons with whom we may share your health/dental /financial information :

Name: _____Phone_____Relationship_____
Name: _____Phone_____Relationship_____
DO NOT SHARE MY INFORMATION WITH ANYONE ELSE _____ (if this is your choice, initial here)_

I, THE UNDERSIGNED, CERTIFY AND ACKNOWLEDGE THE FOLLOWING:

I assign all third party payments to this practice.
I authorize this office to release any health information for the use of treatment, payment, and healthcare operations which includes insurance companies, specialists, and other healthcare providers and institutions.
I acknowledge that I was given a copy of the Practice's Notice of Privacy Practices, and it is posted on the practice's website as well as posted in their office. If you have not received one, please ask our front desk team member for a copy now.
I am 18 years or older. If you are under 18, your parent or guardian must sign this form.
I understand that x-rays and other diagnostic tests may be recommended and denial of these tests can result in undiagnosed and untreated oral conditions.
I am the responsible party and assume responsibility for all the costs, regardless of insurance coverage. (Medicaid excluded)
I assume responsibility for all costs of collections, including collection agency fees, finance charges, attorney fees, court costs, and other such collection related fees.
I understand that dental insurance companies rarely cover 100% of all dental expenses.
I understand how my insurance company will pay for services rendered at this practice. (If not, ask us to now)
I understand that dental treatment carries with it some statistical risks even when performed with the utmost care.
I understand that my appointment times are reserved specifically for me, and I must contact the office no less than 48 hours before concerning any changes. I understand that there may be a charge if I do not.
I confirm that I understand everything on this form, have read all the above information, and have accurately and completely answered all the questions.
I give consent for this practice to photograph any tissue, bone, or anatomical structures for purposes of diagnosis, treatment, patient education, or medical/dental research. I understand that any photographs or x-rays taken in this office may include identifiable characteristics.

Signature_____ Relationship to Patient_____Date Signed _____
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