Welcome
Welcome
Welcome

# WELCOME TO OUR PRACTICE

## PATIENT INFORMATION

Date _____

1.IP

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. _____ Last Name _____ Nickname _____

Sex: ❑ Male ❑ Female Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____

Street _____ City _____ State _____ Zip _____

Home Tel.( _____) _____ Cell.( _____) _____ Circle your preferred contact? Home Work Cell Email

Referred By _____ (FIRST NAME) _____ (LAST NAME) Has a family member ever been a patient of our practice? ❑ Yes ❑ No

Previous Dentist _____ (FIRST NAME) _____ (LAST NAME) Medical Doctor _____ (FIRST NAME) _____ (LAST NAME) Orthodontist _____ (FIRST NAME) _____ (LAST NAME)

Driver's Lic.# _____ Nearest relative not living with you _____ (FIRST NAME) _____ (LAST NAME) Tel.( _____) _____

Employer _____ Bus. Tel.( _____) _____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

### Who will be responsible for your account?

(If self, skip to next section) ❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

Name _____ (FIRST NAME) _____ (LAST NAME) S.S.# _____ Birth Date _____ Age _____ Tel.( _____) _____

Street _____ City _____ State _____ Zip _____

Employer _____ Bus. Tel.( _____) _____

### Spouse or other guarantor information (*if different from above*)

Name _____ (FIRST NAME) _____ (LAST NAME) Relation _____ S.S.# _____ Birth Date _____

Street _____ City _____ State _____ Zip _____

Tel. ( _____) _____ Employer _____ Bus. Tel.( _____) _____

## INSURANCE INFORMATION

1.I0

**Student:** ❑ Full Time ❑ Part Time ❑ Not ❑ Married ❑ Divorced ❑ Legally Separated ❑ Widow ❑ Single

School Info _____ (SCHOOL NAME) _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

**Employed:** ❑ Full Time ❑ Part Time ❑ Retired ❑ Not Please complete both dental and medical insurance information below:

### PRIMARY DENTAL INSURANCE COMPANY

❶

**Employer** _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.( _____) _____ Plan _____

1.I1

**Ins. Co. Name** _____

Address _____ (ADDRESS)

_____ (CITY) _____ (STATE) _____ (ZIP) Tel.( _____) _____

**Group #** _____ **Group Name** _____

**Insured Party** _____ (FIRST NAME) _____ (LAST NAME) Relation _____ (self/spouse/child/other)

Sex: ❑ M ❑ F Birth Date _____ S.S. # _____

Address _____

_____ (CITY) _____ (STATE) _____ (ZIP)

Tel.( _____) _____ I.D. # _____

### PRIMARY MEDICAL INSURANCE COMPANY

**Employer** _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.( _____) _____ Plan _____

**Ins. Co. Name** _____

Address _____ (ADDRESS)

_____ (CITY) _____ (STATE) _____ (ZIP) Tel.( _____) _____

**Group #** _____ **Group Name** _____

**Insured Party** _____ (FIRST NAME) _____ (LAST NAME) Relation _____ (self/spouse/child/other)

Sex: ❑ M ❑ F Birth Date _____ S.S. # _____

Address _____

_____ (CITY) _____ (STATE) _____ (ZIP)

Tel.( _____) _____ I.D. # _____

### SECONDARY DENTAL INSURANCE COMPANY

❷

**Employer** _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.( _____) _____ Plan _____

**Ins. Co. Name** _____

Address _____ (ADDRESS)

_____ (CITY) _____ (STATE) _____ (ZIP) Tel.( _____) _____

**Group #** _____ **Group Name** _____

**Insured Party** _____ (FIRST NAME) _____ (LAST NAME) Relation _____ (self/spouse/child/other)

Sex: ❑ M ❑ F Birth Date _____ S.S. # _____

Address _____

_____ (CITY) _____ (STATE) _____ (ZIP)

Tel.( _____) _____ I.D. # _____

### SECONDARY MEDICAL INSURANCE COMPANY

**Employer** _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.( _____) _____ Plan _____

**Ins. Co. Name** _____

Address _____ (ADDRESS)

_____ (CITY) _____ (STATE) _____ (ZIP) Tel.( _____) _____

**Group #** _____ **Group Name** _____

**Insured Party** _____ (FIRST NAME) _____ (LAST NAME) Relation _____ (self/spouse/child/other)

Sex: ❑ M ❑ F Birth Date _____ S.S. # _____

Address _____

_____ (CITY) _____ (STATE) _____ (ZIP)

Tel.( _____) _____ I.D. # _____

## DENTAL & MEDICAL Hx

**To our patients:** Although dentists primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the care, that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason for today's office visit

Y / N Are you in good health? Last Dental Exam or X-rays Cleaning
Y / N Prior bad dental experience? What do you fear the most about dental treatment?
Y / N Are you under the care of a physician? Date of last visit
*If so, for what are you being treated?*
Y / N Have you had any illness, operation or been hospitalized in the past five years?
*If so, describe*
Y / N Do you clench or grind your teeth?
Y / N Does your jaw click or pop? Do you have muscle pain? Where?
Y / N Does your gum bleed or hurt? *If so, describe where*
Y / N Are you happy with your teeth/smile? Y / N Would you like your teeth whiter?

| | HAVE YOU HAD OR DO YOU CURRENTLY HAVE. . . | Yes | No | NOTES |
|---|---|---|---|---|
| 106 | Rheumatic fever? | | | |
| 107 | Damaged heart valves / mitral valve prolapse? | | | |
| 108 | Heart murmur? | | | |
| 109 | High blood pressure? | | | |
| 110 | Low blood pressure? | | | |
| 111 | Chest pain / angina? | | | |
| 112 | Heart attack(s)? | | | |
| 113 | Irregular heart beat? | | | |
| 114 | Cardiac pacemaker? | | | |
| 115 | Heart surgery? | | | |
| 116 | Pneumonia, bronchitis, chronic cough? | | | |
| 117 | Asthma? | | | |
| 118 | Hay fever / sinus problems? | | | |
| 119 | Snoring / sleep apnea? | | | |
| 120 | Difficult breathing / other lung trouble? | | | |
| 121 | Tuberculosis? | | | |
| 122 | Emphysema? | | | |
| 123 | Do you smoke? If so, # packs a day _____ | | | |
| 124 | Do you use chewing tobacco? | | | |
| 125 | Blood transfusion? | | | |
| 126 | Blood disorder such as anemia? | | | |
| 127 | Bruise easily? | | | |
| 128 | Bleeding tendency / abnormal bleed? | | | |
| 129 | Hepatitis, jaundice, or liver disease? | | | |
| 130 | Infectious mononucleosis? | | | |
| 131 | Gallbladder trouble? | | | |
| 132 | Fainting spells? | | | |
| 133 | Convulsions / epilepsy? | | | |
| 134 | Stroke? | | | |

| | HAVE YOU HAD OR DO YOU CURRENTLY HAVE. . . | Yes | No | NOTES |
|---|---|---|---|---|
| 135 | Thyroid trouble? | | | |
| 136 | Diabetes? | | | |
| 137 | Low blood sugar? | | | |
| 138 | Kidney trouble? | | | |
| 139 | Are you on dialysis? | | | |
| 140 | Swollen ankles, arthritis or joint disease? | | | |
| 141 | Osteoporosis / Osteopenia? | | | |
| 142 | Osteonecrosis? | | | |
| 143 | Stomach ulcers? | | | |
| 144 | Contagious diseases? | | | |
| 145 | Sexually transmitted diseases? | | | |
| 146 | Are you immunosuppressed? possibly from transplant surgery, etc. | | | |
| 147 | Problems with the immune system? possibly from medication / surgery, etc. | | | |
| 148 | Delay in healing? | | | |
| 149 | A tumor or growth? | | | |
| 150 | Cancer / radiation therapy chemotherapy? | | | |
| 151 | Chronic fatigue / night sweats? | | | |
| 152 | Are you on a diet? | | | |
| 153 | A history of drug abuse? | | | |
| 154 | A history of alcohol abuse? | | | |
| 155 | Contact lenses? | | | |
| 156 | Eye disease / glaucoma? | | | |
| 157 | Mental health problems? | | | |
| 158 | A removable dental appliance? | | | |
| 159 | Pain and clicking of jaws when eating? | | | |
| 160 | Have you, or a family member, had any unusual or serious reactions to general anesthesia? | | | |

Please Note: All numbering is not sequential.

## *MEDICATION – Are you now taking. . .*

| | | Yes | No | NOTES |
|---|---|---|---|---|
| 201 | Any kind of medication, drug, pills? | | | |
| 202 | Blood thinners (Coumadin, Plavix Aspirin, Vitamin E, Ginko Biloba)? | | | |
| 203 | Have you ever taken diet pills? | | | |
| 204 | Any natural product, herbal supplement or homeopathic remedy? | | | |
| 205 | Have you ever taken any bone density medications / Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)? | | | |
| 206 | Have you ever taken tranquilizers, sleeping pills, anti depressants, and / or narcotics on a regular basis? If so, please list: | | | |

207 Please list any medications you are currently taking and for what?

| *MEDICATION* | *DOSAGE* | *FREQUENCY* | *MEDICATION* | *DOSAGE* | *FREQUENCY* |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

## *ALLERGIES – Are you allergic to, or had a reaction to. . .*

| | | Yes | No | NOTES |
|---|---|---|---|---|
| 208 | Local anesthetic (numbing med.)? | | | |
| 209 | Penicillin? | | | |
| 210 | Other antibiotics? | | | |
| 211 | Sulfa Drugs? | | | |
| 212 | Sodium pentothal, Valium, or other tranquilizers? | | | |
| 213 | Aspirin? | | | |
| 214 | Codeine or other narcotics? | | | |
| 215 | Other medications? | | | |
| 216 | Latex? | | | |
| 217 | Soy? | | | |
| 218 | Eggs / Yolk? | | | |
| 219 | Sulfites? | | | |
| 220 | Please list any allergies other than drug allergies: | | | |

Physician: _____ Phone: _____ Fax: _____
Address: _____
_____
_____

**Is there any condition concerning your health that the Doctor should be told about?**
❑ **Yes** ❑ **No** ***(if so, describe)*** _____

**Do you wish to speak to the doctor privately about anything?**
❑ **Yes** ❑ **No**

Is there a **FAMILY HISTORY** of:
301 **Cancer:** ❑ Yes ❑ No
302 **Diabetes:** ❑ Yes ❑ No
303 **Heart Disease:** ❑ Yes ❑ No
304 **Anesthetic Problems:** ❑ Yes ❑ No

**IN CASE OF EMERGENCY, CONTACT:**
Name _____
Home Tel.( _____) _____ Bus. Tel.( _____) _____

**IS THIS VISIT RELATED TO AN ACCIDENT?** **Automobile:** ❑ Yes ❑ No
**Work Related** ❑ Yes ❑ No
**Date of Injury** _____ **Other:** ❑ Yes ❑ No

Insurance company handling this claim _____
Claim number _____
Name of Attorney / Adjustor _____
Telephone Number (_____) _____

**THIS SECTION (401-404) IS FOR WOMEN ONLY, MEN CONTINUE BELOW. WOMEN, CONTINUE BELOW WHEN YOU HAVE COMPLETED THIS SECTION.**

401 Is there a possibility of pregnancy? ❑ Yes ❑ No
402 Expected delivery date _____ / _____ / _____
403 Are you nursing? ❑ Yes ❑ No
404 Are you taking birth control pills? ❑ Yes ❑ No

***Women Note:*** *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.*

I certify that I have answered all questions truthfully and to the best of my knowledge in order for the doctor to provide me dental care in a safe manner. It is my responsibility to update any changes to the above information. I will not hold the doctor or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

**Signature of Patient:** *(Parent or Guardian if minor)* **X** **Reviewed by:** **X** **Date:** **X**

## FEES AND PAYMENTS

I agree to pay for all dental services provided to me or my dependents, due and payable at time of service unless prior arrangements have been made. I'm responsible for paying any deductible, co-insurance or any other balance not paid by my insurance plan. If payments are not received upon due date, I understand that a 1.5% monthly finance charge (18% APR) may be added to my account, in addition to any late charges. I will also be responsible for all collection costs, attorney fees, and court costs incurred in collecting your account.

*Initials* _____ I acknowledge that a current copy of the Dental Materials Fact Sheet has been made available to me and is also posted in the office availabe for review anytime.
*Initials* _____ I acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me and is also posted in the office available for review anytime.
I authorize your office to share my information with the following individual(s): Name: _____ Relationship: _____ Name: _____ Relationship: _____

I authorize the release of any health or personal information to process my insurance claims and the same information to other healthcare providers/specialistsis involved in my care.

**Signature of Patient:** *(Parent or Guardian if minor)* **X** **Date:** **X**

This signature on file is my authorization to direct payment of the dental/medical insurance benefits otherwise payable to me, directly to the above named dental entity. This assignment of benefits will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be as valid as the original.

**Insured/Authorized Person Signature:** *(Parent or Guardian if minor)* **X** **Date:** **X**

## AUTHORIZATION

I authorize the doctor to take appropriate X-rays, study models, videos/photographs, or other diagnostic aids for the purpose of diagnosis and treatment planning. I consent that images of the patient's face, jaw, and teeth may be shown to others for treatment purposes, lectures, journals, or advertisements (website, newspapers, magazines, etc.) but that name and personal information will be kept confidential. I DO NOT expect compensation, financial, or otherwise, for the use of such images.

**Witness:** **X**

**X** **Date** **X** **Signature of Patient** *(Parent or Guardian if minor)*

**Doctor:** **X**

**I authorize the doctor to perform all treatment and any changes mutually agreed upon by me and to use the appropriate medication/therapy indicated for such treatment.** I understand that using anesthetics embodies certain risks. I also authorize doctor to choose and employ such assistance as deemed fit to provide the recommended treatment.

**Signature of Patient:** *(Parent or Guardian if minor)* **X** **Date:** **X**