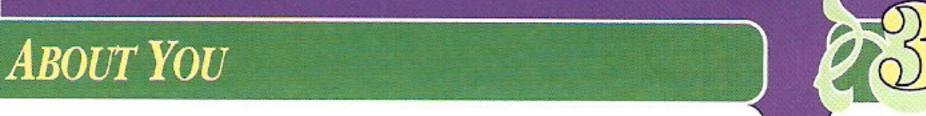


he benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum

oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

DENTAL INSURANCE



E-mail Address:
Name: LAST FIRST MI MR MRS MS DR
I prefer to be called: FIRST MI MR MRS MS DR
Birthdate:/ Age: SS #:
Home Address:
APT / CONDO #
Single Married Divorced Widowed Separated
Hm #: () Pager / Cell #:
Wk #: () Ext: DL #:
Employer:
Employer's Address:
How long there? Occupation:
Where & when are best times to reach you?
Whom may we Thank for referring you?
Other family members seen by us:
Previous / Present Dentist:
Last Visit Date:
SPOUSE INFORMATION
His / Her Name:
Employer:
Wk #: () Ext: SS #:
Birthdate:/ DL #:
Person Responsible for Account:
Wk #: () Ext: Hm #: ()
Billing Address:
Relation: SS #:
Employer: DL #:

Today's Date: _____

Primary Dental Insurance
Insurance Co. Name:
Insurance Co. Address:
Insurance Co. Phone #: ()
Group # (Plan, Local or Policy #):
Insured's Name: Relation:
Insured's Birthdate:/ Insured's ID #:
Insured's Employer:
Employer's Address:
Secondary Dental Insurance
Insurance Co. Name:
Insurance Co. Address:
Insurance Co. Phone #: ()
Group # (Plan, Local or Policy #):
Insured's Name: Relation:
Insured's Birthdate:/ Insured's ID #:
Insured's Employer:
Employer's Address:

In the event of an emergency, is there someone
who lives near you that we should contact?

His / Her Name: _______ Relation: ______

Wk #: (________ Hm #: (_________

MEDICAL HISTORY

Do you have a personal physician? Yes No

	o you	have o	ı persona	l physician?	Yes	■ No
Physician's Name):					
Wk #: ()			Date of	f last visit:		
Are you currently	under th	e care o	f a physician	?	Yes	□ No
Please Explain: _						

CONTINUED ON BACK

MEDICAL HISTORY continued DENTAL HISTORY Why have you come to the dentist today? Your current physical health is: Good Fair Poor Are you taking any prescription / over-the-counter or supplement drugs? Yes No Please list each one: Do you require antibiotics before dental treatment? Are you currently in pain? Do you smoke or use tobacco in any other form? Yes No Have you ever had a serious / difficult problem associated with Have you ever taken Phen-Fen? (Also known as Redux or Pondimin) Yes No any previous dental work? No If so, when? Do you now or have you ever experienced pain / For Women: Are you using a prescribed method of birth control? discomfort in your jaw joint (TMJ / TMD)? Are you pregnant? Yes No Week #: Your current dental health is: Good Fair Poor Are you nursing? Yes No Do you like your smile? Do your gums ever bleed? ■ No Have you ever had any of the following disease Have you ever had periodontal disease? No or medical problems? (Please circle option that applies) How many times a week do you floss? _____ a day do you brush? _____ Anemia / Radiation Treatment Y N Hemophilia / Abnormal Bleeding Type of bristles? Hard Medium Soft Artificial Bones / Joints / Valves Hepatitis High / Low Blood Pressure Arthritis Asthma HIV+ / AIDS **Blood Transfusion** Hospitalized for Any Reason Cancer / Chemotherapy Kidney Problems understand that the information that I have given Mitral Valve Prolapse Congenital Heart Defect today is correct to the best of my knowledge. I also Y N Psychiatric Problems Diabetes Difficulty Breathing Rheumatic / Scarlet Fever understand that this information will be held in the strictest YN Drug / Alcohol Abuse Y N Severe / Frequent Headaches confidence and it is my responsibility to inform this office of any Emphysema / Glaucoma YN Shingles changes in my medical status. I authorize the dental staff to Epilepsy / Seizures / Fainting Spells Y N Sickle Cell Disease / Traits perform any necessary dental services that I may need during Fever Blisters / Herpes Y N Sinus Problems diagnosis and treatment with my informed consent. Heart Attack / Stroke Y N Tuberculosis (TB) Ulcers / Colitis Heart Murmur YN Heart Surgery / Pacemaker Y N Venereal Disease Signature Date Please list any serious medical condition(s) that you have ever had: Payment is due in full at the time of treatment unless prior arrangements have been approved. Are you allergic to any of the following? Y N Erythromycin Thank you for filling out this form completely. It will Aspirin Y N Penicillin Codeine Y N Jewelry / Metals Y N Tetracycline enable us to help you more effectively. If you have **Dental Anesthetics** Y N Other Y N Latex questions at any time, please ask us. We are happy to help. Please list any other drugs / materials that you are allergic to: Our office is HIPAA Compliant and committed to meeting or exceeding the HEREBY AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL DIRECTLY TO THE BELOW NAMED DENTAL ENTITY. COSTS OF DENTAL TREATMENT. SIGNED (INSURED PERSON) SIGNED (PATIENT, OR PARENT IF MINOR) I verbally reviewed the medical / dental intormation above with the patient named herein. Initials: Date: Doctor's Comments: MEDICAL HISTORY UPDATE Comments: Signature: 1. Date: _____ Signature: 1. Date: Comments: Signature: 1. Date: Comments: