

WELCOME TO OUR PRACTICE

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can serve you.

1. About You

Today's date: _____

Name: _____

Home Address: _____

Home Tel.#: _____

Birthdate: __/__/__

SS#: _____

Employer: _____

Employer's Address: _____

Wk.#: _____ Ext: _____

What is the best time to reach you?

Whom may we Thank for referring you? _____

2. Spouse information

His/Her Name: _____

Employer: _____

Wk: _____ Ext: _____

3. Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address/Tel#: _____

Group# _____

Insured's Name: _____ Rel: _____

Insured's Birthdate: __/__/__ SS#: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address/Tel#: _____

Group # _____

Insured's Name: _____ Rel: _____

Insured's Birthdate: __/__/__ SS#: _____

Insured's Employer: _____

4. Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full is expected at each appointment.

Cash Personal Chk Visa/Mastercard

Discover American Express Payment Plan

Release and Authorization

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered during the period of such Dental care to my insurance carrier and/or other health practioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on the behalf of my dependents.

I understand the filing of my insurance benefits is done as a courtesy to me, and in no way relieves me of the responsibility for the payment of any services received.

I understand that canceling or failing an appointment without 24 hours advance notice may result in a failed appointment charge of up to \$15 per 15 minutes of scheduled time being billed to my account.

X _____ Date: _____

WELCOME TO OUR PRACTICE

5. Medical History

Physician's Name: _____

Physician's Tel#: _____

Your current health is: __Good__Fair__Poor

Are you currently under a doctor's care? Y N

Please explain: _____

Are you taking any prescription medicines? Y N

Please list each one: _____

Do you need to be pre-medicated with an antibiotic before dental work? Y N

Have you ever had any of the following diseases or problems?

- | | |
|-------------------------------|----------------------------------|
| Y N Heart Attack/Stroke | Y N Diabetes/TB |
| Y N Cancer/Chemotherapy | Y N Drug/Accohol Abuse |
| Y N Heart Murmur | Y N Veneral Disease |
| Y N Rheumatic Fever | Y N Hemophilla Abnormal Bleeding |
| Y N HIV+Aids | Y N Ulcers/Colitis |
| Y N Heart Surgery | Y N Congenital Heart Defect |
| Y N Pacemaker | Y N Anemia/Radiation Therapy |
| Y N Shingles | Y N Asthma/Arthritis |
| Y N Mitral Valve Prolapse | Y N Difficulty breathing |
| Y N Kidney/liver problems | Y N Hepatitis |
| Y N Artificial bones/joints | Y N Blood Transfusion |
| Y N Sinus Problems | Y N Emphysema |
| Y N High/low Blood Pressure | Y N Glaucoma |
| Y N Frequent Severe Headaches | Y N Fever Blisters |
| Y N Epilepsy/Seizures | |

Please list any other medical conditions you have/had not listed above: _____

Are you allergic to any of the following?

- | | | |
|------------------------|--------------------------|-------------|
| Y N Penicillin | Y N Tetracycline | Y N Latex |
| Y N Aspirin | Y N Erthromycin | Y N Codeine |
| Y N Dental Anesthetics | Y N Others (Please List) | |

For Women

Are you taking birth control pills? Y N

Are you pregnant ? Y N Due Date: _____

Are you nursing? Y N

6. Dental History

Previous/Present

Dentist: _____

Last

visit: _____

Why have you come to the dentist today?

Are you currently in pain? Y N

Have you ever had a serious/difficult problem associated with dental work?

Y N

Have you ever experienced pain/discomfort in your jaw joint(TMJ)?

Y N

Your current dental health is:

___Good ___Fair ___Poor

Do you like your smile? Y N

Do your gums ever bleed? Y N

How many times a day do you brush? ___

How many times a week do you floss? ___

Type of toothbrush bristles:

___Hard ___Medium ___Soft

Do you smoke? Y N

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my health status. I request the dental staff to perform any dental services necessary with my informed consent that I may need during diagnosis and treatment.

X _____ Date: _____

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help!