WELCOME!

Today's Date: ______________________________

ABOUT YOU

First Name: ______________________________ *Middle Initial:* _______ *Last Name:* ______________________________

Address: ____
Street City State Zip Code

Date of Birth: _________________________ *Sex:* ❑ Male ❑ Female *Height:* _______________ *Weight:* _______________

Email: ____ *Social Security Number:* ______________________________

Home Phone: ____ *Mobile Phone:* ____

Marital Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Other

Employer: __________________________________ *Occupation:* ________________________ *Work Phone:* __________________

Employer Address: ____
Street City State Zip Code

Referred By: ____

SPOUSE INFORMATION

First Name: ______________________________ *Middle Initial:* _______ *Last Name:* ______________________________

Address: ____
Street City State Zip Code

Date of Birth: _________________________ *Sex:* ❑ Male ❑ Female *Social Security Number:* _________________________

Home Phone: ____ *Mobile Phone:* ____

EMERGENCY CONTACT

Name: ____________________________ *Relation to you:* _______________________ *Cell Phone:* _______________________

Address: ____
Street City State Zip Code

Full Name: ______________________________

INSURANCE INFORMATION

Primary Insurance Company: ____________________ *Policy Holder Name:* ____________________

Policy Holder's DOB: ________________ *Policy Holder's ID #:* ____________ *Group #:* ____________

Ins. Co. Address: ____
Street City State Zip Code

Insurance Company Phone: ____________________ *Insurance Company Fax:* ____________________

Secondary Ins Company: ____________________ *Policy Holder Name:* ____________________

Policy Holder's DOB: ________________ *Policy Holder's ID #:* ____________ *Group #:* ____________

Ins. Co. Address: ____
Street City State Zip Code

Insurance Company Phone: ____________________ *Insurance Company Fax:* ____________________

DENTAL HISTORY

Reason for today's visit: ____________________ *Date of last dental visit:* ____________________

How often do you floss? ____________________ *How often do you brush?* ____________________

History of allergic reaction to local or general anesthetics? ______ *If yes, Please explain:* ____________________

Have you had trouble from previous dental care? __________ *If yes, Please explain:* ____________________

Cigarette, pipe, or cigar smoking: ____________________ *If yes, how many packs per day:* ____________________

PLEASE CHECK IF YOU HAVE/HAD

❑ ***NONE***

- ❑ *Smokeless tobacco use*
- ❑ *Bad Breath*
- ❑ *Blisters*
- ❑ *Burning sensation*
- ❑ *Clenching*
- ❑ *Dry mouth*
- ❑ *Gums swollen, tender, or bleeding*
- ❑ *Sensitivity*
- ❑ *Loose teeth or broken fillings*
- ❑ *Mouth breathing*
- ❑ *Orthodontic treatment*
- ❑ *Periodontal treatment*
- ❑ *Food collection between teeth*
- ❑ *Head, neck, or jaw pain ache*

FAMILY DENTISTRY on park

Full Name: ____________________

MEDICAL HISTORY

Physician name: ____________________ *Date of last visit:* ____________________

Physician Phone: ____________________ *Physician Fax:* ____________________

Pharmacy Name: ____________________ *Pharmacy Phone:* ____________________

Are you pregnant or nursing? ❑ Yes ❑ No *If yes please explain:* ____________________

Have you ever had a blood transfusion? ❑ Yes ❑ No *If yes please explain:* ____________________

Do you need antibiotics prior to dental work? ❑ Yes ❑ No *If yes please explain:* ____________________

Have you had any serious illnesses or operations? ❑ Yes ❑ No *If yes please explain:* ____________________

Have you had any artificial joint replacement? ❑ Yes ❑ No *If yes please explain:* ____________________

Are you currently taking any Medications? ❑ Yes ❑ No *If yes please list:* ____________________

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PLEASE CHECK IF YOU HAVE/HAD: ❑ ***NONE***

❑ *Hay fever, sinusitis*
❑ *Diabetes*
❑ *Arthritis, Rheumatism*
❑ *Artificial Heart Valves*
❑ *Asthma*
❑ *Herpes*
❑ *Asthma: Used Steroid*
❑ *Jaundice*
❑ *Low Blood Pressure*
❑ *Pacemaker*
❑ *Respiratory Disease*
❑ *Kidney Disease*
❑ *Stroke*
❑ *Tonsillitis*
❑ *Venereal Disease*
❑ *HIV/AIDS*
❑ *Cough, persistent or bloody*
❑ *Chemotherapy*
❑ *Emphysema*
❑ *Epilepsy*
❑ *Asthma: Req'd Hospitalization*
❑ *Heart Problems*
❑ *Headaches*
❑ *Cancer (Type ____________)*
❑ *High Blood Pressure*
❑ *Radiation Treatments*
❑ *Scarlet Fever*
❑ *Chemical Dependency*
❑ *Swelling of feet/Ankles*
❑ *Tumor or Growth*
❑ *Unexplained Weight Loss*
❑ *Disorders*
❑ *Anemia*
❑ *Mitral Valve Prolapse*
❑ *Circulatory Problems*
❑ *Cortisone Treatments*
❑ *Glaucoma*
❑ *Fainting*
❑ *Heart Murmur*
❑ *Hepatitis (Type ____________)*
❑ *Osteopenia*
❑ *Rheumatic Fever*
❑ *Shortness of Breath*
❑ *Blood Disease, Clotting Disorders*
❑ *Thyroid Problems*
❑ *Ulcer*
❑ *Contact lenses*
❑ *Immune Deficiency*
❑ *Bleeding abnormally with operation/surgery*
❑ *Other* ____________________
❑ *Do you consume alcoholic beverages? If yes, How often?* ____________________

ALLERGIES

❑ *None* ❑ *Seasonal* ❑ *Latex* ❑ *Hives* ❑ *Food:* ____________ ❑ *Medications:* ____________

Other(Specify): ____________________ *Explain:* ____________________

Full Name: ______________________________

AUTHORIZATION AND RELEASE

APPOINTMENT POLICY: PLEASE NOTIFY THIS OFFICE 24 HOURS PRIOR TO AN APPOINTMENT IF YOU MUST CANCEL. THIS OFFICE RESERVES THE RIGHT TO CHARGE A $50 PER HALF HOUR CANCELLATION FEE.

Patient's Signature: ______________________________ *Date:* ______________________

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing the incorrect information can be dangerous to my health. I hereby authorize this office to administer and perform the necessary procedures, such as x-rays, anesthetics and dental treatment deemed necessary or advisable with the diagnosis of my dental condition. I understand there are certain risks inherent in dental treatment; such as but not limited to: pulpal sensitivity or damage, tissue swelling or brushing, soreness of jaws, paresthesia and other procedure specific risks.

I understand that I am responsible for payment of services by this office, and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize this office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submission, whether manual or electronic.

Patient's Signature: ______________________________ *Date:* ______________________

Our office is HIPAA compliant and is committed to exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

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