WELCOME TO OUR PRACTICE

PATIENT INFORMATION...

Date 03/19/2024

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

Sex: ❑ Male ❑ Female Birth Date ____ Age ____ Social Security Number ____

Street ____ Apt. ____ City ____ State ____ Zip ____

Home Tel.(____) ____ Cell.(____) ____ E-mail ____

Did you find our practice online? ❑ Yes ❑ No Referred By ____ (FIRST NAME) ____ (LAST NAME)

Have you ever been a patient of our practice? ❑ Yes ❑ No Has a family member ever been a patient of our practice? ❑ Yes ❑ No

Dentist ____ (FIRST NAME) ____ (LAST NAME) Medical Doctor ____ (FIRST NAME) ____ (LAST NAME)

Preferred Pharmacy ____ Tel.(____) ____

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

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

In case of emergency, please contact ____ Tel. (____) ____ Relation ____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT...

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other ____

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

Street ____ Apt. ____ City ____ State ____ Zip ____

Driver's Lic.# ____ Employer ____ Bus. Tel.(____) ____

SPOUSE OR OTHER GUARANTOR INFORMATION (if different from above)...

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

Street ____ Apt. ____ City ____ State ____ Zip ____

Tel. (____) ____ Employer ____ Bus. Tel.(____) ____

INSURANCE INFORMATION...

Student: .... ❑ Full Time ❑ Part Time ❑ Not .... School Name and Address ____ (SCHOOL NAME) ____ (ADDRESS)

Marital Status: .. ❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated ____ (CITY) ____ (STATE) ____ (ZIP)

Employed: .... ❑ Full Time ❑ Part Time ❑ Retired ❑ Not................................. Do you belong to a PPO or HMO? ❑ Yes ❑ No

PRIMARY INSURANCE COMPANY...

Insurance Type: ❑ **Dental** ❑ **Medical**

Employer ____

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

Bus. Tel.(____) ____ Plan ____

Ins. Co. Name ____ I.D. # ____

Address ____ (ADDRESS) ____ (CITY)

____ (STATE) ____ (ZIP) Tel.(____) ____

Group # ____ Group Name ____

Insured Party ____ (FIRST NAME) ____ (LAST NAME) Relation ____

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

Street ____ City ____

State, Zip ____ Tel.(____) ____

SECONDARY INSURANCE COMPANY...

Insurance Type: ❑ **Dental** ❑ **Medical**

Employer ____

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

Bus. Tel.(____) ____ Plan ____

Ins. Co. Name ____ I.D. # ____

Address ____ (ADDRESS) ____ (CITY)

____ (STATE) ____ (ZIP) Tel.(____) ____

Group # ____ Group Name ____

Insured Party ____ (FIRST NAME) ____ (LAST NAME) Relation ____

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

Street ____ City ____

State, Zip ____ Tel.(____) ____

DENTAL INFORMATION...

Reason for today's visit ____ Are you in pain? ❑ Yes ❑ No, For How Long? ____

Please indicate any of the following problems by checking off the corresponding box:

❑ Discomfort, clicking, or popping in jaw
❑ Red, swollen, or bleeding gums
❑ A removable dental appliance
❑ Blisters / sores in or around the mouth
❑ Prolonged bleeding from an injury / extraction
❑ Recent infections or sore throat
❑ My teeth are sensitive to: ❑ Hot ❑ Cold ❑ Sweets ❑ Biting

❑ Lost / broken filling(s)
❑ Teeth grinding / clenching
❑ Ringing in ears
❑ Broken / chipped tooth
❑ Gum disease
❑ Other

❑ Stained teeth
❑ Locking jaw
❑ Bad breath
❑ Burning tongue / lips
❑ Toothache

❑ Difficulty closing jaw
❑ Difficulty opening jaw
❑ Loose / shifting teeth
❑ Food caught between teeth
❑ Swelling / lumps in mouth

Last dental exam ____ Last dental x–rays ____ Times a day you brush? ____ Times a week you floss? ____

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best) Would you like whiter teeth? ❑ Yes ❑ No

What type of toothbrush bristles do you use? ❑ Soft ❑ Medium ❑ Hard

MEDICAL HISTORY...

Patient Name ____________________

Are you in good health? ❑ Yes ❑ No • Height __________ Weight __________ • Are you under the care of a physician? ❑ Yes ❑ No

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ❑ Yes ❑ No

Have you had any illness, operation, or been hospitalized in the past five years? ❑ Yes ❑ No

Have you ever had general anesthesia? ❑ Yes ❑ No • Have you, or a family member, had any unusual or serious reactions to general anesthesia? ❑ Yes ❑ No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y N
✔ ❑ Rheumatic fever
❑ ❑ High blood pressure
❑ ❑ Low blood pressure
❑ ❑ Mitral valve prolapse
❑ ❑ Heart murmur
❑ ❑ Chest pain / Angina
❑ ❑ Heart attack(s)
❑ ❑ Irregular heart beat
❑ ❑ Cardiac pacemaker
❑ ❑ Heart surgery
❑ ❑ Damaged heart valves
❑ ❑ Pneumonia / Bronchitis / Chronic cough
❑ ❑ Chronic fatigue / Night sweat
❑ ❑ Trouble climbing 1-2 flights of stairs
❑ ❑ Anemia
❑ ❑ Asthma
❑ ❑ Mental health problems

Y N
❑ ❑ Problems with immune system *(possibly from med. / surg.)*
❑ ❑ Delay in healing
❑ ❑ Hay fever / Sinus problems
❑ ❑ Snoring
❑ ❑ Sleep apnea / CPAP
❑ ❑ Respiratory problems
❑ ❑ Tuberculosis
❑ ❑ Emphysema
❑ ❑ Do you smoke or vape
If so, how much a day __________
❑ ❑ Do you use chewing tobacco
❑ ❑ A history of marijuana or other drug use
❑ ❑ A history of alcohol abuse
❑ ❑ Abnormal bleeding
❑ ❑ Bleeding tendency

Y N
❑ ❑ Blood transfusion
❑ ❑ Blood disorder
❑ ❑ Bruise easily
❑ ❑ Eye disease / Glaucoma
❑ ❑ Jaundice / Liver disease
❑ ❑ Hepatitis
❑ ❑ Gallbladder trouble
❑ ❑ Fainting spells
❑ ❑ Convulsions / Epilepsy
❑ ❑ Stroke
❑ ❑ Thyroid trouble
❑ ❑ Diabetes
❑ ❑ Low blood sugar
❑ ❑ Are you on dialysis
❑ ❑ Kidney trouble
❑ ❑ Sexually transmitted diseases
❑ ❑ COVID–19

Y N
❑ ❑ Contagious diseases
❑ ❑ Infectious mononucleosis
❑ ❑ Swollen ankles
❑ ❑ Arthritis / Joint disease
❑ ❑ Prosthetic implant
❑ ❑ Joint replacement
❑ ❑ Osteoporosis / Osteopenia
❑ ❑ Osteonecrosis
❑ ❑ Stomach ulcers / acid reflux
❑ ❑ GI troubles / IBS / Colitis
❑ ❑ Tumor or growth
❑ ❑ Cancer / Radiation / Chemotherapy
❑ ❑ Are you on a diet
❑ ❑ Contact lenses

MEDICATION & ALLERGIES...

Are you now taking:

Y N
❑ ❑ Nerve pills
❑ ❑ Diet pills

Y N
❑ ❑ Pain killers (including aspirin)
❑ ❑ Tranquilizers

Y N
❑ ❑ Muscle relaxers
❑ ❑ Insulin

Y N
❑ ❑ Stimulants
❑ ❑ Antidepressants
❑ ❑ Blood thinners (Coumadin, Aspirin, Eliquis, Xarelto)
❑ ❑ Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, Prolia, Xgeva, or Evista in the past 12 years?

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

Are you allergic to, or had a reaction to:

Y N
❑ ❑ Penicillin
❑ ❑ Sodium pentothal / Valium / other tranq.
❑ ❑ Soy

Y N
❑ ❑ Sulfa drugs
❑ ❑ Aspirin
❑ ❑ Eggs / Yolk

Y N
❑ ❑ Local anesthetic (numbing med)
❑ ❑ Codeine or other narcotics
❑ ❑ Sulfites

Y N
❑ ❑ Amoxicillin
❑ ❑ Latex
❑ ❑ Do you have any known allergies

Please list any other medication or antibiotic you are allergic to:

MEDICATION / ANTIBIOTIC NAME	MEDICATION / ANTIBIOTIC NAME

Please list any allergies other than drug allergies:

1-4 below for women only: *(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.)*

1) Is there a possibility of pregnancy? ❑ Yes ❑ No

2) Expected delivery date: ____________________

3) Are you nursing? ❑ Yes ❑ No

4) Are you taking birth control pills: ❑ Yes ❑ No

Patient Name ______________________________

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

❏ I permit the office to communicate with me via text message on my cell phone.

X ______________________ **X** ______________________ **X** ____________

Signature of patient *(Parent or Guardian if Minor)* **Reviewed by** **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

X ______________________________ **X** ____________

Signature of patient *(Parent or Guardian if Minor)* **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X ______________________________ **X** ____________

Signature of patient *(Parent or Guardian if Minor)* **Date**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X ______________________________ **X** ____________

Signature of patient *(Parent or Guardian if Minor)* **Date**

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