"Let Our Family Treat Your Family"

Name: Dr/Mr/Mrs/Miss/Ms: ________________________________MI: ______ Sex: M/F DOB: __________
Address: ____ SS#_________________________________
City: ____________________________________State: __________________Zip: ______________________
Home Phone: ______________________Work Phone: _________________ Cell Phone: ________________
Patient Email (or Guardian): ____
Responsible Party: _______________________________________SS#_______________DOB: ___________
Spouse: Mr/Mrs: ____ SS#_______________DOB: ___________
How did you hear about our office? ___________________________
Emergency Contact (Name):_____________________ Relation: ____________ Phone #___________________

OFFICE FINANCIAL POLICY
We accept cash/checks/Visa/MasterCard/American Express/Discover and Care Credit
(Care Credit up to 12 months interest free!)
THE AMOUNT NOT COVERED BY INSURANCE IS DUE AT TIME OF SERVICE

Dental Insurance Information

Name of Insured Employee: _____________________________Relationship to patient: ____________
Insured's Employer: ________________________________Phone: ______________________________
Dental Insurance Company: ______________________Phone: ________________ Group#__________
Coverage: Self Only: _______ Self and Spouse________ Family_______ Self and Dependents_______
Do you have additional dental Insurance? Yes / No

Medical History Information

Former Dentist: ________________________________Phone#____________________ Date last seen: ____________________

Primary Care Physician's Name: __________________ Phone# _____________________ Date last seen: _____________________

Are you currently under medical treatment now? YES / NO If yes, please explain: ____

Do you use tobacco? YES/ NO / PAST USE Do you take blood thinners? YES/ NO Do you take daily aspirin? YES/ NO

Do you take (or have you taken) bone strengthening medications? YES / NO |If you answered YES, taken via IV or pills (circle one).

Have you taken any medications for prostate conditions YES/NO | If YES, via IV or pills (circle one) Drug name ________________

Are you diabetic? YES/ NO | If Yes, Type I or Type II (circle one) and what was your last HbA1c _______ test date______________

Have you had a heart attack, TIA, or stroke? YES/NO | If Yes, Cardiologist/Neurologist Name_______________date____________

Are you taking opioid or barbiturate or pain medications? YES/NO | Have you experienced drug/alcohol addiction? YES/NO

Have you taken steroids in the past year? YES/NO | If Yes, medication________dose_______ frequency_______ duration_______

Do you use any recreational drugs or alcohol? YES/NO (this is confidential) Please describe: ______________________________

____

Please indicate here if an attachment with additional drug information is appended: YES / NO

Are there any other medical or dental history or other information we should know about? (Please describe below)

____

____

Today's Date: _______________Patient Initials:______________

What are your goals for your dental treatment and what is your chief concern at this time? How can we make you smile?

____
____
____
____

Do you have dental anxiety? NO / MILD / MODERATE / SEVERE | Do you have GERD/Acid Reflux? YES/NO Dry Mouth? YES / NO

Past medical history			
Do you now or have you ever had:			
❑ Diabetes	❑ A-Fib	❑ Emphysema/COPD	❑ Jaundice
❑ High blood pressure	❑ Heart murmur	❑ Gout	❑ Hepatitis
❑ High cholesterol	❑ Infective Endocarditis	❑ Sjogrens Syndrome	❑ Liver Impairment
❑ Hypo ❑ Hyer -thyroidism	❑ Congenital heart defect prosthetic, or graft	❑ TMJ Joint Pain	❑ Stomach or peptic ulcer
❑ Bleeding Disorder		❑ Arthritis	❑ Rheumatic fever
❑ Cancer (type) ____________________	❑ Pneumonia	❑ Cataracts	❑ Tuberculosis
	❑ Pulmonary embolism	❑ Kidney disease	❑ HIV/AIDS
❑ Head/Neck Radiation Therapy	❑ Asthma	❑ Lupus	❑ Herpes / Cold Sores
❑ Leukemia	❑ Alzeheimers/Dimentia	❑ Sinus Trouble	❑ Currently Pregnant
❑ Psoriasis	❑ Parkinsons	❑ Kidney stones	❑ Fibromyalgia
❑ Angina	❑ Epilepsy (seizures)	❑ Crohn's disease	❑ Anemia
❑ Heart Attack (MI)	❑ Stroke	❑ Colitis	❑ Depression/Anxiety
Other medical conditions (please list):			

Allergies

ALLERGIC TO: NONE
Seasonal
Any Metals
Barbiturates
Opioids/Codeine
Iodine
Latex Rubber
Anesthetics/Novocain
Penicillin/Antibiotics
Sulfa Drugs
Acrylic
Other: ___________

Please describe your reaction to any items you marked as allergies:

____
____

CURRENT MEDICATIONS			
Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:			
Name of drug	**Reason you take drug**	**Dose/Frequency**	**Duration**
1.			
2.			
3.			
4.			
5.			
6.			

Authorization and Release

I hereby consent to treatment as necessary or desirable to the care of the patients named above, including but not restricted to whatever drugs, medicine, performance of medical/dental procedures, x-rays, or other studies that the doctor orders. It is essential the performance of good dentistry that the dentist have a full understanding of the physical well-being of the patient. Your cooperation in submitting this information is greatly appreciated and will enable us to serve your particular needs safely and with greater satisfaction. All information is confidential. I also acknowledge full responsibility for the payment of services and agree to pay for them in full at time of service, unless other arrangements have been made. 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 authorize and request my insurance to pay directly to the dentist or dental group benefits otherwise payable to me. I understand that my dental pays less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (or responsible party if patient is under age 18:) X________________________________Date:________________

Name of Signer (print) ______________________________ Relationship SELF / PARENT-GUARDIAN / POA ______________________