****IMPORTANT: 24 HOUR NOTICE IS REQUIRED FOR CANCELING AN APPOINTMENT TO AVOID A $50 CANCELATION FEE****

PATIENT INFORMATION

Date:_____ SS#_____
Last Name_____
First Name_____Middle Initial____
Address_____
Cell #_____Home#_____
Email_____
City_____State_____Zip_____
Sex: ☐M ☐F Age_____ Birthday_____
Circle one:
☐Married ☐Widowed ☐Single
☐Separated ☐Divorced ☐Partnered
Patient: Employer/School_____
Occupation_____
Employer/School address_____
_____Phone#_____
Spouse/Partner's Name_____
Cell Phone #_____
Whom may we thank for referring you?
_____

EMERGENCY CONTACT (Someone that does not live in your household)

Name_____
Phone_____

YOUR CHILD _____

Sex ☐M ☐F Nickname_____
Birthday_____ Age_____
Child's Home Address_____
City_____State_____ZIP_____

WHO IS RESPONSIBLE FOR MAKING APPOINTMENTS?

Name_____Relationship_____
Phone_____Work #_____

MOTHER'S NAME_____
Address_____
City_____State_____ZIP_____
Phone_____Work#_____
Email_____
Employer_____
SS#_____

FATHER'S NAME_____
Address_____
City_____State_____ZIP_____
Phone_____Work#_____
Email_____
Employer_____
SS#_____

PRIMARY DENTAL INSURANCE

Who is responsible for this account?_____
Birthdate_____ SS#_____
Relationship to Patient?_____
Insurance Co._____
Group#_____
Policy#_____
Is Patient covered by additional insurance? ☐Yes ☐No

SECONDARY DENTAL INSURANCE

Who is responsible for this account?_____
Birthdate_____SS#_____
Relationship to Patient?_____
Insurance Co._____
Group#_____
Policy#_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with (Name of Insurance Company(ies):_____ and assign directly to Dr._____ all insurance benefits. I understand that I am financially responsible for all charges whether paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits.

_____
Signature of Patient/Parent/Guardian or Personal Representative

_____
Print name of Patient/Parent/Guardian or Personal Representative

_____ _____
Date Relationship to Patient

The names below may have access to my health records:

NAME_____
Phone_____ Relationship_____
NAME_____
Phone_____ Relationship_____
NAME_____
Phone_____ Relationship_____

I acknowledge receipt of privacy practices and **HIPAA** Privacy Policy states that our office will not release our medical information without consent.

Print_____
Signature_____
Date_____

DENTAL HISTORY: Reason for todays visit _____ Today's Date _____

Former Dentist: _____ City _____ State _____ Phone# _____

Date of Last Dental Visit _____ Date of Last Dental X-rays _____ HOW OFTEN DO YOU BRUSH _____ FLOSS _____

Please circle the "yes" or "no" to indicate if you have had any of the following:

Bad breath	yes	no	Dry mouth	yes	no	Lip or cheek biting	yes	no	Pain around ear	yes	no
Bleeding gums	Yes	no	Fingernail biting	Yes	no	Loose teeth	Yes	no	Periodontal Treatment	yes	no
Broken fillings	Yes	no	Food collection between teeth	Yes	no	Mouth/lip blisters	Yes	no	Circle if applies: Sensitivity to cold/hot/sweets	Yes	no
Burning sensation on tongue	Yes	no	Grinding teeth	Yes	no	Mouth pain (or pain when brushing)	Yes	no	Sensitivity when biting	yes	no
smoking	Yes	no	Gums swollen or tender	Yes	no	Mouth breathing	Yes	no	Sores in your mouth	Yes	no
Clicking or jaw popping	Yes	no	Jaw pain or tiredness	Yes	no	Orthodontic treatment	Yes	no			

Physician's Name _____ Date of Last Visit _____

Have you ever used a **Bisphosphonate medication**? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "**fen-phen**?" These include combinations of Lonimin, Adipex, Fastin (brand name of Phentermine), Pondimin (Fenfluramine) and Redux (Dexfenfluramine). ☐ Yes ☐ No

Please circle the "yes" or "no" if the patient has any of the following:

AIDS/HIV	Yes	No	Emphysema	Yes	No	Radiation Treatment	Yes	No
Anemia	Yes	No	Epilepsy	Yes	No	Respiratory Disease	Yes	No
Arthritis, Rheumatism	Yes	No	Fainting or Dizziness	Yes	No	Rheumatic Fever	Yes	No
Artificial Heart Valves	Yes	No	Headaches	Yes	No	Scarlet Fever	Yes	No
Artificial Joints	Yes	No	Heart Murmur	Yes	No	Shortness of Breath	Yes	No
Asthma	Yes	No	Heart Problems	Yes	No	Sinus Trouble	Yes	No
Back Problems	Yes	No	Hepatitis Type _____	Yes	No	Skin Rash	Yes	No
Bleeding abnormally with extractions/surgery	Yes	No	Herpes	Yes	No	Stroke	Yes	No
Blood disease	Yes	No	High Blood Pressure	Yes	No	Swollen Feet/Ankles	Yes	No
Cancer	Yes	No	Jaw Pain	Yes	No	Swollen Neck Glands	Yes	No
Chemical Dependency	Yes	No	Kidney Disease	Yes	No	Thyroid Problems	Yes	No
Chemotherapy	Yes	No	Liver Disease	Yes	No	Tonsillitis	Yes	No
Circulatory problems	Yes	No	Low Blood Pressure	Yes	No	Tuberculosis	Yes	No
Congenital Heart Lesions	Yes	No	Mitral Valve Prolapse	Yes	No	Tumor or growth on head or neck	Yes	No
Cortisone Treatments	Yes	No	Nervous Problems	Yes	No	Ulcer	Yes	No
Cough, persistent or bloody	Yes	No	Pacemaker	Yes	No	Weight Loss, unexplained	Yes	No
Diabetes, Type_____	Yes	No	Psychiatric Care	Yes	No	Other:	yes	

Women:

Are you pregnant? ☐ Yes ☐ No Due Date _____ Nursing? ☐ Yes ☐ No

Taking Birth Control? ☐ Yes ☐ No What Type _____

LIST ANY **MEDICATIONS** THE PATIENT IS TAKING AND THE DOSAGE:

	Aspirin Local Anesthetic
	Barbiturates (sleeping pills) Penicillin
	Codeine Sulfa
	Iodine Latex
	Other:
Pharmacy Name:	
Pharmacy Phone #	

CIRCLE ANY **ALLERGIES** THAT APPLY TO THE PATIENT