

PATIENT INFORMATION

Date: _____ NEW PATIENT UPDATE
Name: _____
LAST FIRST MI PREFERRED TITLE
 MALE FEMALE CHILD* STUDENT** SINGLE MARRIED DIVORCED WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

PARENT/GUARDIAN NAME(S)

Patient Date of Birth: _____ Patient SSN: _____
Address: _____
HOME #: _____
CELL #: _____
CITY ST ZIP CODE
E-Mail: _____
Referral? Yes No Referred by: _____

EMERGENCY INFORMATION

In case of emergency, please provide information for a designated contact:

NAME RELATIONSHIP Phone: _____

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____
Address: _____
WORK #: _____
CITY ST ZIP CODE
E-Mail: _____

INSURANCE INFORMATION

Subscriber: _____
LAST FIRST MI PREFERRED TITLE
Subscriber Date of Birth: _____ Subscriber SSN: _____
Subscriber Employer: _____
Patient Relationship to Subscriber: SELF SPOUSE CHILD OTHER

PRIMARY INSURANCE CARRIER:

Group/Policy No.: _____ ID No.: _____
Address: _____ TEL: _____
TOLL-FREE: _____
FAX: _____
CITY ST ZIP CODE

SECONDARY INSURANCE CARRIER:

Group/Policy No.: _____ ID No.: _____
Address: _____ TEL: _____
TOLL-FREE: _____
FAX: _____
CITY ST ZIP CODE

PREVIOUS DENTIST INFORMATION

Dentist: _____ Telephone: _____
Clinic/Facility: _____
Address: _____
CITY ST ZIP CODE
Reason for changing: _____

DENTAL HISTORY

ORAL HEALTH: EXCELLENT GOOD FAIR POOR
Date of Last Dental Visit: _____ Treatment Type: _____

Y N Are you currently having dental discomfort? If yes, explain: _____
 Y N Any unhappy/unpleasant dental experiences? If yes, explain: _____
 Y N Any injuries to mouth/teeth/head? If yes, explain: _____
 Y N Any missing teeth other than wisdom teeth or orthodontic extractions?
 Y N Have missing teeth been replaced?
 Y N Orthodontic appliances now or in the past?
 Y N Gums bleed when brushing or flossing?
 Y N Concerned about gum disease? History of gum disease? Y N
 Y N Any concerns about the appearance of your teeth?
 Y N Does it hurt to bite or chew?
 Y N Do you clench or grind your teeth? If so, do you wear a night guard or splint? Y N
 Y N Do you want to become a regular continuing care patient in our practice?
 Y N Do you want your mouth properly restored and pain free?
 Y N Does any type of dental treatment make you nervous? If yes, please explain below:

The most important concerns regarding my dental treatment are:

What factors are most important for your satisfaction with our office?

Any additional concerns/comments?

CHILD/MINOR PATIENTS: PLEASE ANSWER THE FOLLOWING QUESTIONS:

Y N Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.)

 Y N Any unusual speech habits? If yes, explain: _____
 Y N Any lost teeth? If yes, list: _____
 Y N Does the patient receive assistance with brushing and flossing? If yes, how often?

MEDICAL HISTORY

GENERAL HEALTH: EXCELLENT GOOD FAIR POOR

- Y N Under a physician's care now?
- Y N Any hospitalization in the past 5 years?
- Y N Any serious illnesses/surgeries?
- Y N Use tobacco in any form? If Yes, Type:
- Y N Is pre-medication required before dental visits due to heart condition or artificial joint?
- Y N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: Y N Currently nursing? Y N Currently pregnant? Due Date:

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): NONE

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> ACID REFLUX | <input type="checkbox"/> BULIMIA | <input type="checkbox"/> HEARING PROBLEMS | <input type="checkbox"/> PSYCHIATRIC TREATMENT |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> CANCER/MALIGNANCY | <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> RADIATION/CHEMO |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> CEREBRAL PALSY | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> RESPIRATORY DISEASE |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> CHEMICAL DEPENDENCY | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> ANOREXIA | <input type="checkbox"/> CHICKEN POX | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> SINUS PROBLEMS |
| <input type="checkbox"/> ANXIETY | <input type="checkbox"/> CONVULSIONS | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> ARTIFICIAL HEART VALVE | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> THYROID CONDITION |
| <input type="checkbox"/> ARTIFICIAL JOINTS | <input type="checkbox"/> DIABETES | <input type="checkbox"/> LIVER PROBLEMS | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> DIZZINESS/FAINTING | <input type="checkbox"/> MITRAL VALVE PROLAPSE | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> EPILEPSY/SEIZURES | <input type="checkbox"/> MONONUCLEOSIS | <input type="checkbox"/> VENEREAL DISEASE |
| <input type="checkbox"/> AUTISM/ASPERGER'S | <input type="checkbox"/> FREQUENT EAR INFECTIONS | <input type="checkbox"/> PACEMAKER | |
| <input type="checkbox"/> BLEEDING DISORDER | <input type="checkbox"/> FREQUENT HEADACHES | <input type="checkbox"/> OTHER – PLEASE LIST: | |

ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

- | | | | | |
|---|----------------------------------|---|---|-------------------------------|
| <input type="checkbox"/> ASPIRIN | <input type="checkbox"/> CODEINE | <input type="checkbox"/> LACTOSE INTOLERANCE | <input type="checkbox"/> SLEEPING PILLS | <input type="checkbox"/> NONE |
| <input type="checkbox"/> ANESTHETIC – LOCAL | <input type="checkbox"/> DAIRY | <input type="checkbox"/> METAL SENSITIVITY | <input type="checkbox"/> SULFA DRUGS | |
| <input type="checkbox"/> BARBITURATES | <input type="checkbox"/> LATEX | <input type="checkbox"/> NITROUS OXIDE SEDATION | <input type="checkbox"/> PENICILLIN/OTHER ANTIBIOTICS | |
| <input type="checkbox"/> OTHER – PLEASE LIST: | | | | |

MEDICATION INFORMATION

ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): NONE

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> ANTIBIOTICS/SULFA DRUGS | <input type="checkbox"/> ANTIHISTAMINES/ALLERGY | <input type="checkbox"/> DAILY ASPIRIN | <input type="checkbox"/> BLOOD PRESSURE MEDICATIONS |
| <input type="checkbox"/> BLOOD THINNERS | <input type="checkbox"/> CANCER/CHEMO MEDICATIONS | <input type="checkbox"/> CORTISONE/STEROIDS | <input type="checkbox"/> HEART MEDICATION/DIGITALIS |
| <input type="checkbox"/> INSULIN | <input type="checkbox"/> NITROGLYCERIN | <input type="checkbox"/> ORAL CONTRACEPTIVES | <input type="checkbox"/> OSTEOPOROSIS MEDICATIONS |
| <input type="checkbox"/> OTHER DIABETIC MEDICATIONS | <input type="checkbox"/> RECREATIONAL DRUGS | <input type="checkbox"/> THYROID MEDICATIONS | <input type="checkbox"/> TRANQUILIZERS |
| <input type="checkbox"/> OTHER (PLEASE LIST BELOW) | | | |

DRUG NAME	DOSAGE	REASON PRESCRIBED

PRIMARY PHYSICIAN INFORMATION

Physician: Telephone:

Clinic/Facility:

Office Policies & Financial Agreement

We are committed to providing you with the best care possible. In order to achieve our goals, we need your assistance and your understanding of our financial guidelines.

Insurance

We are in network with most PPO dental insurance companies. Please contact us if you have questions regarding your insurance benefits.

- **No estimate is a guarantee of payment.** You are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.
- **Claims will not be made to any secondary insurance companies.**

Payments

- **Patient portion or patient co-pay is due at the time services are rendered** - unless prior financial arrangements have been made.
- **Payment methods:**
 - o All major credit cards are accepted
 - o Cash
 - o Various payment options available upon request

Cancelled and Missed Appointments

- **Please give 48 hours notice** if you are unable to keep your reserved appointment.
- **Cancelled or missed appointments without 48 hours notice** will be charged \$35.00

By signing below I acknowledge I have read and understand the guidelines above.

Signature: _____

Date: _____