



### Patient Information

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Preferred Name \_\_\_\_\_ Gender: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Family Status \_\_\_\_\_ Social Security#: \_\_\_\_\_

Email Address: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ ext: \_\_\_\_\_ (Cell): \_\_\_\_\_

Address (Street): \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Whom may we thank for referring you to our practice? \_\_\_\_\_

### Insurance Information

#### Primary Insured Persons Information:

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ ID or SS#: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Group Number: \_\_\_\_\_

Patient's relationship to insured: (Self): \_\_\_\_\_ (Spouse): \_\_\_\_\_ (Child): \_\_\_\_\_ (Other): \_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

#### Secondary Insured Persons Information:

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ ID or SS#: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Group Number: \_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

### Person Responsible Party Information

Person Responsible for Account: (Print Name) \_\_\_\_\_

I accept responsibility for payment of all dental services rendered in this office for myself and my dependents regardless of what insurance benefits may apply. Payment is due at the time of service and I understand that financial arrangements MUST be made prior to dental appointments. Assignment of insurance benefits, if applicable, is a courtesy extended to me and does not replace my responsibility for all charges incurred. Your signature will also allow us by law to prepare your insurance forms and assist in making collections from insurance companies to credit your account. It is our policy to charge \$50 for a history of missed appointments without 24 hour notice.

Patient/Responsible Party: (Signature): \_\_\_\_\_ Date: \_\_\_\_\_

### Red Flag

The federal Red Flag Law requires all healthcare practices to obtain, verify, and record information that identifies every patient (new & existing). A digital photo will be taken at your appointment to be used as a permanent record of your identity.

## Health Information

PLEASE LIST CURRENT MEDICATIONS YOU ARE TAKING: \_\_\_\_\_

Have you ever had or have any of the following? Please circle YES or NO:

Y N	AIDS/HIV +	Y N	Epilepsy/Seizures	Y N	Respiratory Problems
Y N	Alzheimer's Disease	Y N	Prolonged Bleeding	Y N	Rheumatic Fever
Y N	Anemia	Y N	Fainting	Y N	Sickle Cell Anemia
Y N	Are you pregnant	Y N	Heart Lesions or	Y N	Stroke
Y N	Artificial Joints		Valve Disorders	Y N	Thyroid Disease
Y N	Artificial Heart Valve	Y N	Hepatitis	Y N	Tuberculosis
Y N	Asthma		Type: A/B/C	Y N	Ulcers
Y N	Blood Disease	Y N	Herpes	Y N	Venereal Disease
Y N	Blood Pressure		Type: I or II	Y N	<b>Allergy: Penicillin</b>
	High or Low	Y N	Jaundice	Y N	<b>Allergy: Latex</b>
Y N	Blood Thinners	Y N	Kidney Disease	Y N	<b>Allergy: Sulfa Drugs</b>
Y N	Blood Transfusion	Y N	Liver Disease	Y N	<b>Allergy: Ibuprofen</b>
Y N	Cancer	Y N	Lung Disease	Y N	<b>Allergy: Aspirin</b>
Y N	Chemotherapy	Y N	Pacemaker	Y N	<b>Allergy: Codeine</b>
Y N	Diabetes	Y N	Psychiatric Care	Y N	<b>Allergy: Epinephrine</b>
	Type: I or II	Y N	Radiation	Y N	<b>Allergies: _____</b>
Y N	Drug Dependency				

Y N Do you smoke or chew tobacco? (how much) \_\_\_\_\_

Y N Have you ever had any complications following dental treatment? Explain: \_\_\_\_\_

Y N Have you been admitted to a hospital or needed emergency care during the past two years? Explain: \_\_\_\_\_

Y N Are you now under the care of a physician? Explain: \_\_\_\_\_

Name of Physician: \_\_\_\_\_ Phone number: \_\_\_\_\_

Y N Do you have any health problems that need further clarification? Explain: \_\_\_\_\_

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## Dental Health History

Name of previous dentist: \_\_\_\_\_ Date of last cleaning: \_\_\_\_\_

Date of last x-rays: \_\_\_\_\_

Y N Do you have a specific dental problem(s)? \_\_\_\_\_

Y N Has it been more than one year since your last dental visit? If yes, date of visit \_\_\_\_\_

Y N Do your gums bleed when you brush?

Y N Do you have any loose or cracked teeth? Where? \_\_\_\_\_

Y N Do you have any missing teeth? Where? \_\_\_\_\_ Was it replaced? \_\_\_\_\_

Y N Do you have pain when chewing?

Y N Do you grind or clench your teeth?

Y N Do you have a Biteguard?

Y N Have you ever had a cold sores/fever blisters? How often? \_\_\_\_\_

Y N Do you want to have whiter teeth?

Y N Would you like to have straighter teeth?

Have you ever had orthodontic treatment? If yes, when? \_\_\_\_\_ Doctor's name \_\_\_\_\_

How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

How do you feel about your smile? \_\_\_\_\_

Is there anything you would change about you smile? \_\_\_\_\_

Please add anything you feel is important: \_\_\_\_\_

Is there anything special we can do to make your visits more comfortable? \_\_\_\_\_