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O ABOUT YOU		
Patient Name		
Last	First	Middle Initial
What you prefer to be called		☐ Male ☐ Female ☐ Other
Birthdate Age		
Mailing Address & Contact Information		
Street	City_	State ZIP
Home Phone		
Email		
Employer		
Employer's Address		
Street	City	State ZIP
Occupation		
Status Minor Single Married Divorced Sepa		
Spouse's name		Do you have children? No Yes How many?
2 INSURANCE INFO		
Primary Dental Insurance		
Company Name		
Street		
Phone		
Insurance ID#		
Insured's Name		
Relation		Birthdate
Insured's Employer		
Secondary Dental Insurance		
Company Name		
Street	City_	State ZIP
Phone		
Insurance ID#	Group# (Plan/Loca	nl/Policy #)
Insured's Name		
Relation		
Insured's Employer		



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loday's Date File #		
3 ACCOUNT INFO		
Person Usually Responsible for the Account		
Full Name	Relation	
Billing Address		
Street	City	State ZIP
Social Security # Driver's License #		State
Work Phone		
Payment Method Cash Check Credit Card		Date
I hereby authorize assignment of my insurance rights and benefits d	irectly to the provider for servi	ices rendered. I fully understand I am solely
responsible for any balance not paid by my insurance company (if of	fered at this office).	
4 EMERGENCY CONTACT		
Emergency Contact Information		
Whom should we contact?		
Relation		
Phones: Home Work Work		
Medical Doctor		
Who is your Medical Doctor?		
Medical Doctor's Phone		



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IODAY'S DATE ——————— FIIE :							
■ DENTAL INFORMATION Reason for today's visit: □ Exam □ Emergency □ Consultation Are you in pain? □ No □ Yes How long?							
Please indicate ☑ any of the following problems:							
Discomfort, clicking or popping of jaw	Lost/broken filling(s)	Stained teeth	☐ Broken/chipped tooth				
☐ Blisters/sores in or around the mouth	☐ Teeth grinding	Locking jaw	Sensitive tooth, teeth, or gums				
Red, swollen or bleeding gums	Ringing in ears	☐ Bad breath	Active decay/cavity(ies)				
Other:							
Who was your previous doctor?							
Street	0	ity	State ZIP				
Your Last Dental Exam X-Rays X-Rays Cleaning Cleaning							
Have you had problems with previous dental treatment? If so, explain: Times a devices. Price to the bright bright problem. Soft Medium. Ulard							
Times a day you Brush Floss Type of tooth brush bristles: Soft Medium Hard							
Your Smile Rate your smile from 1 (poor) to 10 (excellent): Things you would change about your smile:	-	Yes No Have ha	rd orthodontic treatment? 🔲 Yes 🔲 No				



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Today's Date _____ File # _____

6 MEDICAL HISTORY & INFORMATION						
Which medications are you taking? ☐ Nerve pills ☐ Pain killers (including aspirin) ☐ Muscle relaxer ☐ Stimulants						
☐ Blood thinners ☐ Tranquilizers ☐ Insulin ☐ Meds for Osteoporosis ☐ Vitamins/Supplements						
Other(s), please list:						
Have you ever taken Bis	phosphonates (ex, Aredia/Fosa	max)? 🗌 Yes 🔲 No Phen-fen/R	edux? 🗌 Yes 🔲 No			
Do you have or have you had any of the following diseases, medical conditions, or procedures?						
YN Heart murmur YN Heart attack/stroke YN Lung disease YN Thyroid problems YN Congenital heart defect YN Cancer/tumor(s)/growth(s) YN Heart disease/angina YN Shingles YN Cancer/tumor(s)/growth(s) YN Heart disease/angina YN Heart disease/angina YN Cancer/tumor(s)/growth(s) YN Heart disease/angina YN Heart disease/angina YN Cancer/tumor(s)/growth(s) YN Heart disease/angina YN Chemotherapy/radiation YN Glaucoma YN Artificial heart valves YN Frequent thirst/urination YN Leukemia YN Chemotherapy/radiation YN Artificial heart valves YN Bleeding problems/anemia YN Chemotherapy/radiation YN Artificial heart valves YN Bleeding problems/un Artificial heart valves YN Bleeding problems/yn Heart disease/angina YN Chemotherapy/radiation YN Artificial heart valves YN Artif						
 						
I			How long? _			
Rate your general health from 1 (poor) to 10 (excellent): Do you wear contact lenses? \subseteq Yes \subseteq No						
For Women: Are you taking birth control pills? 🔲 Yes 🔲 No 🛮 Are you taking hormonal replacement? 🔲 Yes 🔲 No						
Are you pregnant? No Yes. How long? Are you nursing? Yes No How many children have you had?						
• We invite you to disc based on a friendly,	Update Office Use					
• Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest chargest and any other expenses incurred in collecting your account.						
 I authorize the staff to authorize the provide 	INITIALS DATE					
 I understand the abo knowledge and under have provided. 	COMMENTS					
I acknowledge that I have received a copy of the Summary of Privacy Notice.				L DATE		
Signature		Date c		COMMENTS		
	☐ Parent/Guardian ☐ Spoo	use				