WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

1) PERSONAL INFORMATION:

DATE_____ LEGAL NAME (First, Middle Initial, Last) _____
WISHES TO BE CALLED _____ BIRTHDATE _____ SS#/SSN _____
☐ Male ☐ Female ☐ Minor ☐Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
EMPLOYER _____ OCCUPATION _____
REFERRED BY _____

2) RESPONSIBLE PARTY (Who is responsible for the account?):

LEGAL NAME (First, Middle Initial, Last) _____
Relationship to patient _____ BIRTHDATE _____
SS#/SSN _____ Driver's License # _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
EMPLOYER _____ OCCUPATION _____
HOME PHONE_____ WORK PHONE _____
CELL PHONE _____

3) CONTACT INFORMATION:

HOME PHONE_____ WORK PHONE _____
CELL PHONE _____
Where do you prefer to receive calls? ☐ Home ☐ Work ☐ Cell
When is the best time to reach you? Time _____ Days _____
Would you like to receive appointment reminders by text message to your cell phone? ☐ Yes ☐ No
EMAIL _____
Would you like to receive appointment reminders by email? ☐ Yes ☐ No
In the event of an emergency, who should we contact?
NAME _____ RELATIONSHIP _____ PHONE _____

4) DENTAL INSURANCE INFORMATION:

Primary Insurance
NAME OF INSURED _____
RELATIONSHIP TO PATIENT_____
INSURED'S DATE OF BIRTH _____
SS#/SSN _____
EMPLOYER _____
INSURANCE COMPANY _____
GROUP# _____
MEMBER ID # _____
INS. CO. ADDRESS _____
_____

Secondary Insurance
NAME OF INSURED _____
RELATIONSHIP TO PATIENT _____
INSURED'S DATE OF BIRTH _____
SS#/SSN _____
EMPLOYER _____
INSURANCE COMPANY _____
GROUP# _____
MEMBER ID # _____
INS. CO. ADDRESS _____
_____

5) AUTHORIZATION AND RELEASE:

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of patient or parent/guardian if minor Date

6) APPOINTMENT POLICY:

Office hours are by appointment, and we do value your time. This office is a private practice dental office and not a dental clinic. Therefore, appointment time is reserved for you alone. When you make an appointment, please be sure that you will be able to keep it.

A) Every effort is made on our part to stay on schedule, so we respectfully ask patients to be prompt and keep their appointments. We ask to be given 24 business hours advance notice if you are unable to make your appointment. We ask that you make sure that we have home, work, and cell numbers to avoid any scheduling difficulties.

B) We reserve the right to charge for missed appointments. The fee is based on the procedure and the amount of time scheduled. Patients who continually fail to show for their appointments will be asked to pre-pay for the procedure in order to be rescheduled. Exceptions to this policy can be determined only on an individual basis.

X_____

Signature of patient or parent/guardian if minor Date

7) PATIENT DENTAL HISTORY:

Name of Previous Dentist and Location _____ Date of Last Exam _____

1.	Do your gums bleed while brushing or flossing?	☐ Yes	☐No
2.	Have you ever had periodontal treatment?	☐ Yes	☐No
3.	Are your teeth sensitive to hot or cold liquids/foods?	☐ Yes	☐No
4.	Are your teeth sensitive to sweet or sour liquids/foods?	☐ Yes	☐No
5.	Do you feel pain to any of your teeth?	☐ Yes	☐No
6.	Do you have any sores or lumps in or near your mouth?	☐ Yes	☐No
7.	Have you had any head, neck, or jaw injuries?	☐ Yes	☐No
8.	Have you ever experienced any of the following problems with your jaw?		
	Clicking?	☐ Yes	☐No
	Pain (joint, ear, side of face)?	☐ Yes	☐No
	Difficulty in opening or closing?	☐ Yes	☐No
	Difficulty in chewing?	☐ Yes	☐No
9.	Do you have frequent headaches?	☐ Yes	☐No
10.	Do you clench or grind your teeth?	☐ Yes	☐No
11.	Do you bite your lips or cheeks frequently?	☐ Yes	☐No
12.	Have you ever had any difficult extractions in the past?	☐ Yes	☐No
13.	Have you ever had any prolonged bleeding following extractions?	☐ Yes	☐No
14.	Have you had any orthodontic treatment?	☐ Yes	☐No
15.	Do you wear dentures or partials?	☐ Yes	☐No
16.	Have you received instructions regarding care of your teeth and gums?	☐ Yes	☐No
17.	Do you like your smile?	☐ Yes	☐No

8) PREMEDICATION:

1.	Have you ever been asked to premedicate prior to any surgery or dental treatment?	☐ Yes	☐No
	If yes, why? _____		
2.	Have you ever had joint replacement or implants (e.g., knees, hips, etc.)?	☐ Yes	☐No