How did you hear about us?

☐ Referral ☐ Website ☐ Insurance Company ☐ Advertisement ☐ Drive By ☐ Online search

Patient Information

Full Name: _____ Preferred Name: _____

Birth date: _____ Social Security #:_____

☐Married ☐Single ☐Child ☐Widowed ☐ Divorced

Household Information *(you only need to complete this section once per family)*

Home Address: _____

City: _____ State: _____ Zip code: _____

Parent/Guardian: _____ Relationship: _____

Contact Information

Work Phone: _____Wireless Phone: _____Home Phone: _____

Employer: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Email (appt. reminders only): _____

How do you prefer we contact you for appointment reminders? ☐Email ☐Text ☐Cell ☐Home phone

Insurance Information

Insurance Carrier: _____

Subscriber's Name: _____

SS#:_____ Subscriber's Birthday: _____

Employer: _____

Privacy Policy

We are committed to keeping all of your information private and will not discuss or share personal information except with those authorized by you. We fully comply with all provisions of HIPAA (Health Insurance Portability and Accountability Act of 1996). You acknowledge that you have been given a copy of the office privacy policies for your review.

Payment Policy

- You agree to be responsible for your own dental bill and to keep us updated of your current insurance information.
- We are happy to bill your insurance as a courtesy; however, you are ultimately responsible for all services performed and charges received whether covered or not.
- All payments and copayments are due at time of service.
- Should collection become necessary, the responsible party agrees to pay an additional 33.3% collection fee, and all legal fees of collection, with or without suit, including attorney fees and court costs
- *There will be a $50 charge added to all accounts for missed appointments without 24 hour notice. Please note that following two missed appointments without notice, future appointments will require prepayment in full for your appointment prior to scheduling. In the event that you miss this appointment without giving 24 hour notice, your prepayment will be applied to your account as a missed appointment fee.*

Signature: _____ Date: _____ Relationship to Patient:_____

Health History

Yes No

☐ ☐ 1. Have you been under a physician's care or had any health problems within the past 2 years?
If yes, explain _____
Physician's name: _____ Phone: _____

2. **Please list ALL medications you currently take AND their purpose:**

1._____ 4_____

2_____ 5. _____

3_____ 6. _____

Yes No

☐ ☐ 3. Do you have any allergies? Please check all appropriate boxes.
☐ Latex ☐ Antibiotics ☐ Metal ☐ Local Anesthetic ☐ Other
Explain _____

☐ ☐ 4. (Women) Are you pregnant or trying to get pregnant?
☐ ☐ 5. Do you have any tooth, oral, or facial pain now? (where?)_____
☐ ☐ 6. Does dental treatment make you nervous?
☐ ☐ 7. Are you interested in cosmetic procedures (bleaching, veneers)?
☐ ☐ 8. Are you interested in braces or Invisalign (adults and youth)?
☐ ☐ 9. Do you have a history of gum disease? (explain) _____
☐ ☐ 10. Do you have any missing teeth? Would you like them them replaced? _____
☐ ☐ 11. Have your wisdom teeth been removed? If yes, ☐All or ☐Some
12. Approximately when was your last dental visit? _____
13. Other information the dentist should know _____

Do you have or have you ever had any of the following?

Yes No

☐ ☐ Heart problems (explain) _____
☐ ☐ Blood disorders (explain) _____
☐ ☐ High Blood Pressure
☐ ☐ Angina/Chest Pain
☐ ☐ Heart Attack (when?) _____
☐ ☐ Stroke (when?) _____
☐ ☐ Require antibiotic premedication
☐ ☐Rheumatic Fever
☐ ☐Prosthetic heart valves
☐ ☐ Pacemaker
☐ ☐ Artificial joints
☐ ☐ Bruise easily
☐ ☐ Hepatitis or liver disease (type?) _____
☐ ☐ HIV or AIDS
☐ ☐ Cancer (type?) _____
☐ ☐ Asthma (last attack?)_____

Yes No

☐ ☐ Diabetes (type?) _____
☐ ☐ Tuberculosis (when?) _____
☐ ☐ Kidney Disease
☐ ☐ Fainting or Seizures
☐ ☐ Arthritis (type?) _____
☐ ☐ Tobacco products (which?)_____
☐ ☐ Alcoholism
☐ ☐ Substance abuse (explain) _____
☐ ☐ Taken medication for Osteoporosis
☐ ☐ Taken Bisphosphonates
☐ ☐ Chronic Click in jaw/TMJ/Neck pain
☐ ☐ Chronic Migraines/ Headaches
☐ ☐ Cold sores/ Mouth Ulcers
☐ ☐ Dry Mouth
☐ ☐ Regular Sinus Problems
☐ ☐ Other _____

I hereby certify that my answers to the forgoing questions are accurate. Since a change in my medical conditions or medications can affect dental treatment, I agree to take the responsibility to notify the dentist of any changes at any subsequent appointment.
Signature_____ Date _____
(Patient, legal guardian or authorized agent of patient)