Language Assistance

Welcome! *Please take a few minutes to fill out this form as completely as you can.*

Patient Information

Name ______________________ M / F Birthdate __________ Marital status: S M D W
Last First Middle

Address ______________________________________ ______________
Street City State Zip Code Phone

Employer ______________________ Work Phone ______________

Social Security No. ______________ Cell Phone ______________ E-mail ______________

Who can we call in case of an emergency? ______________ Phone ______________

Who can we thank for referring you? ______________________

How do you prefer to receive appointment reminders? ☐ phone ☐ text ☐ e-mail

Dental Insurance

Name of Insured ______________________ Insured's Date of Birth __________

Name of Insuring Employer ______________________ Social Security or Policy ID # ______________

Name of Dental Insurance Company ______________________ Group # ______________

Relationship to Insured: ☐ self ☐ spouse ☐ dependent

Is the patient covered by any other dental insurance? *Yes* *No*

If you have secondary insurance, see back.

Medical History

Physician ______________________ Phone ______________ Date of Last Visit __________

Pharmacy ______________________ Phone ______________

Medications you are currently taking:

____
____
____
____
____
____

Do you take any medications now, including regular dosages of aspirin? *Yes* *No*

Do you take or have you ever taken bisphosphonate drugs? *Yes* *No*

Do you smoke? *Yes* *No*

I am ALLERGIC to: ☐ Penicillin ☐ Codeine ☐ Latex ☐ ______________

☐ **NO KNOWN ALLERGIES**

HAVE YOU EVER BEEN TREATED FOR or DO YOU HAVE: Check (*X*) the appropriate box

☐ Mitral valve prolapse	☐ Heart attack	☐ Asthma	☐ Alcohol/Drug addiction
☐ Artificial heart valve	☐ Angina	☐ Diabetes	☐ Cancer
☐ Congenital heart disease	☐ Fainting spells	☐ Epilepsy/Seizures	☐ Depression
☐ Artificial joint replacement	☐ Hepatitis	☐ Tuberculosis	☐ Sinus problems
☐ Rheumatic fever	☐ Anemia	☐ Stroke	☐ HIV infection/AIDS
☐ High or low blood pressure	☐ Osteoporosis	☐ Bleeding problems	☐ Thyroid problems

Do you have or have you had any disease, condition or problem not listed? *Yes* *No*

If yes, please describe ______________________

WOMEN ONLY: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking birth control pills?

	Medical History Update			
Date				
Initial				

To the best of my knowledge, the questions pertaining to my health history have been answered accurately. I will inform the dentist or the office staff of any changes in my health or medications.

X ______________________ __________
Patient, Parent or Guardian Signature Date

Please Complete Both Sides

Dental History

I am here today for: ☐ Check-up ☐ Consultation ☐ Pain/Swelling ☐ Broken Tooth ☐ ____________

	Yes	No
Do your gums bleed while brushing or flossing?	☐	☐
Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
Do you feel pain in any of your teeth?	☐	☐
Do you have any sores or lumps in your mouth?	☐	☐
Does food collect between your teeth?	☐	☐
Do you grind or clench your teeth?	☐	☐
Have you experienced problems in your jaw?	☐	☐
Do you have frequent headaches?	☐	☐

Do you wear full dentures or partials? *Yes* *No* If yes, year of placement ____________

Have you ever worn braces on your teeth? *Yes* *No* If yes, year of removal ____________

Have you had any periodontal (gum) treatment? *Yes* *No* If yes, year of treatment ____________

Yes *No* Have you ever had instructions on the proper care of your teeth and gums?

Yes *No* If you could have your teeth whitened, would you be interested?

Yes *No* Are you aware of any loose teeth or broken fillings?

Yes *No* Are you happy with your smile?

Have you had a full mouth series of x-rays or a panoramic x-ray within the last 3 years? ***Yes*** ***No*** **Date of last x-rays** ________

May we contact your previous dentist for your x-rays and records? *Yes* *No* Previous dentist ____________________

Secondary Insurance

Name of Insured ____________________ Insured's Date of Birth __________

Name of Insuring Employer ____________________ Social Security or Policy ID # __________

Name of Dental Insurance Company ____________________ Group # __________

Relationship to Insured: ☐ self ☐ spouse ☐ dependent

Authorizations

I authorize the dentist and the dental staff to perform any necessary dental services that I may need during diagnosis and treatment.

I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the release of all information necessary to secure the payment of benefits. ***I understand that I am responsible for all charges for services rendered whether or not paid by my insurance.***

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that a copy of this office's ***Notice of Privacy Practices,*** which contains a description of the uses and disclosures of my health information, is available at my request.

X ______________________________ ____________

Patient, Parent or Guardian Signature **Date**

1100 DENTAL©
Your neighborhood dentists