ACCOUNT INFORMATION

PATIENT NAME _____ ____ ____
FIRST MI LAST AGE SEX

ADDRESS _____**APT. NO.**_____

CITY _____**STATE** _____**ZIP**_____

BIRTHDATE _____**SSN** _____-_____-_____
MONTH DAY YEAR

HOME PHONE: ( )_____

WORK PHONE: ( )_____

MOBILE PHONE:( )_____

TEXT: Y N

_____
E-MAIL ADDRESS

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

EMPLOYER NAME_____ **OCCUPATION** _____

EMPLOYER ADDRESS_____

CITY _____**STATE** _____**ZIP**_____

IF THE PERSON RESPONSIBLE FOR THE ACCOUNT IS DIFFERENT THAN THE PATIENT, PLEASE FILL IN THIS SECTION:

NAME_____RELATIONSHIP_____
FIRST MI LAST

ADDRESS_____APT. NO._____

CITY_____STATE_____ZIP_____

BIRTHDATE_____SSN_____-_____-_____
MONTH DAY YEAR

EMPLOYER _____ADDRESS_____

HOME PHONE ( )_____

WORK PHONE ( ) _____

MOBILE PHONE ( )_____

_____
E-MAIL ADDRESS

_____ _____ _____ _____
EMERGENCY CONTACT NAME **TELEPHONE #** **ALTERNATE TEL #** **RELATIONSHIP**

DENTAL INSURANCE SCANNED INTO RECORD OR PROVIDED BELOW:

INSURANCE COMPANY NAME:_____

ADDRESS_____

CITY_____STATE_____ZIP_____

PHONE ( )_____GROUP NUMBER_____

POLICY NUMBER_____EFFECTIVE DATE_____

INSURED IF DIFFERENT THAN PATIENT:

NAME _____RELATIONSHIP_____

ADDRESS_____

CITY_____STATE_____ZIP_____

BIRTHDATE_____SSN_____-_____-_____

EMPLOYER_____

PATIENT TREATMENT CONSENT:

- I authorize the Dentist(s), Dental Hygienist(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me.
- I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This Form also authorizes this Practice to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE". I authorize my Dentist(s) to release treatment records/x-rays or any other information deemed pertinent to my insurance carrier as necessary/or requested.
- I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that any unpaid claims the carrier does not pay or any balance that extends beyond 60 days from the date of treatment may be assessed a service charge of 1 1/2% per month.

Patient/Parent or Guardian Signature:_____**Date:**_____

I have been given the opportunity to read the **Notice of Privacy Practices** and obtain a copy.

Patient/Parent or Guardian Signature:_____**Date:**_____

PATIENT NAME:_____**DOB**_____
FIRST MI LAST

WHAT IS THE REASON FOR THIS APPOINTMENT? _____

ARE THERE ANY SPECIFIC DENTAL CONCERNS WE SHOULD BE AWARE OF?_____

DO YOU THINK YOU HAVE ANY DECAY OR CAVITIES ? YES NO HOW OFTEN DO YOU BRUSH? _____

DO YOUR GUMS BLEED EASILY WHEN BRUSHING OR FLOSSING? YES NO HOW OFTEN DO YOU FLOSS? _____

DO YOU SUFFER FROM CHRONIC BAD BREATH OR BAD TASTE? YES NO DO YOU HAVE ANY JAW JOINT CRACKING OR PAIN ? YES NO

WHAT WAS THE PURPOSE OF YOUR LAST DENTAL APPOINTMENT? _____ WHEN WAS THAT? _____

WHEN WAS THE LAST TIME YOU HAD A DENTAL CLEANING? _____NAME OF PREVIOUS DENTIST? _____

WHEN WERE THE LAST FULL MOUTH X-RAYS TAKEN ON YOUR TEETH? _____

HOW WOULD YOU DESCRIBE YOUR DENTAL HEALTH? (Please circle): EXCELLENT GOOD FAIR POOR

WHAT WOULD YOU LIKE TO CHANGE ABOUT YOUR SMILE?_____

MEDICAL HISTORY:

Information that you feel insignificant could be directly related to your dental health. Please answer all questions. This information is strictly confidential.

DO YOU HAVE OR HAVE YOU EVER BEEN TREATED FOR:

	YES NO		YES NO		YES NO
HEART PROBLEMS	Y N	DO YOU SMOKE?	Y N	ALLERGIC REACTION (HIVES/SWELLING)TO:	
HEART MURMUR*	Y N	LUNG/BREATHING PROBLEMS	Y N	PENICILLIN	Y N
MITRAL VALVE PROLAPSE*	Y N	ASTHMA	Y N	ERYTHROMYCIN	Y N
HEART VALVE REPLACEMENT*	Y N	BRONCHITIS	Y N	SULFA	Y N
RHEUMATIC FEVER*	Y N	EMPHYSEMA	Y N	CODEINE	Y N
ARTIFICIAL JOINT(S) WHERE?	Y N	TUBERCULOSIS	Y N	ASPIRIN	Y N
ANGINA	Y N	SINUS TROUBLE	Y N	LATEX	Y N
STROKE	Y N	ARTHRITIS	Y N	LOCAL ANESTHETIC (NOVOCAIN)	Y N
HEART ATTACK	Y N	DIFFICULTY IN HEALING	Y N	OTHER MEDICATIONS OR	Y N
BLOOD TRANSFUSIONS	Y N	DIABETES	Y N	SUBSTANCES? Please list: _____	
BYPASS	Y N	THYROID PROBLEMS	Y N	_____	
SNORE	Y N				
PACE MAKER	Y N	ADRENAL/PITUITARY PROBLEMS	Y N	CANCER/TUMOR	Y N
HIGH BLOOD PRESSURE	Y N	LIVER PROBLEMS/DYSFUNCTION	Y N	OTHER GROWTHS	Y N
LOW BLOOD PRESSURE	Y N	HEPATITIS/JAUNDICE	Y N	CHEMOTHERAPY	Y N
ANY BLEEDING DISORDERS	Y N	KIDNEY PROBLEMS	Y N	RADIATION THERAPY	Y N
ANEMIA	Y N	STOMACH PROBLEMS/ULCERS	Y N	SEXUALLY TRANSMITTED DISEASES	Y N
HEMOPHILIA	Y N	NERVOUS OR MENTAL DISORDER	Y N	OTHER INFECTIOUS DISEASES	Y N
SICKLE CELL TRAIT	Y N	EPILEPSY OR SEIZURES	Y N	HIV/AIDS	Y N
GRIND TEETH	Y N	ALCOHOLISM	Y N	ARE YOU PREGNANT?	Y N
		DRUG ABUSE	Y N	IF YES, DUE DATE:	

*DO YOU NEED TO TAKE ANTIBIOTIC PREMEDICATION PRIOR TO DENTAL APPOINTMENTS? YES NO DON'T KNOW

NAME OF ANTIBIOTIC: _____

DO YOU HAVE ANY CURRENT HEALTH PROBLEMS NOT NOTED ABOVE? YES NO WHAT? _____

ARE YOU CURRENTLY BEING TREATED BY A PHYSICIAN? YES NO WHY? _____

PHYSICIAN'S NAME, ADDRESS AND PHONE: _____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS, VITAMINS, PILLS OR TONICS: YES NO LIST: (1)_____FOR: _____

(2)_____FOR _____ (3) _____FOR _____ (4) _____FOR: _____

IS THERE ANY CONDITION OR PROBLEM RELATING TO YOUR MEDICAL OR HISTORY THAT HAS NOT BEEN MENTIONED? YES NO

EXPLAIN:_____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I WILL INFORM THE PROVIDER OF ANY CHANGES IN MY HEALTH STATUS OR MY MEDICATIONS.

_____ _____
DATE PATIENT/GUARDIAN SIGNATURE