PATIENT INFORMATION

WELCOME TO OUR DENTAL PRACTICE

Name: _____ Preferred Name: _____ Driver's Lic. #: _____

Address: _____ (STREET) _____ (CITY/STATE/ZIP)

Employer: _____ Occupation: _____

Work Address: _____ (STREET) _____ (CITY/STATE/ZIP) Work Phone: _____

Home Phone: _____ Cell Phone: _____ May we call you at work? ☐ Yes ☐ No

Social Security #: _____ Birthdate: _____ Sex: M / F Marital Status: _____

E-Mail Address: _____ Do you regularly check your email? _____

How did you hear about our practice? _____ Do you accept text messaging? ☐ Yes ☐ No

PERSON RESPONSIBLE FOR PAYMENT OR ACCOUNT ☐ SAME AS PATIENT

Name: _____ Relationship to patient: _____

Home Address: _____ (STREET) _____ (CITY/STATE/ZIP)

Employer: _____ Occupation: _____

Work Address: _____ (STREET) _____ (CITY/STATE/ZIP) Work Phone: _____

Home Phone: _____ Cell Phone: _____ May we call you at work? ☐ Yes ☐ No

Social Security #: _____ Birthdate: _____ Driver's Lic. #: _____

E-Mail Address: _____ Sex: _____ Marital Status: _____

IS THERE ANYONE ELSE RESPONSIBLE FOR THIS PATIENT'S ACCOUNT? ☐ NO ☐ YES, Fill Out Lines Below

Name: _____ Relationship to patient: _____

Home Address: _____ (STREET) _____ (CITY/STATE/ZIP) Work Phone: _____

Home Phone: _____ Cell Phone: _____ May we call you at work? ☐ Yes ☐ No

Social Security #: _____ Birthdate: _____ Driver's Lic. #: _____

DENTAL INSURANCE INFORMATION

Primary Insurance Company: _____

Group #: _____

Employer: _____

Subscriber's Name: _____

Relationship to patient: _____

Subscriber Social Security or ID #: _____ DOB _____

Union or Local #: _____

SECONDARY INSURANCE INFORMATION

Primary Insurance Company: _____

Group #: _____

Employer: _____

Subscriber's Name: _____

Relationship to patient: _____

Subscriber Social Security or ID #: _____ DOB _____

Union or Local #: _____

Name of school if patient is a student: _____

Emergency Contact: _____ **Phone Number(s):** _____

Advanced Dental Center treats patients based on their dental needs and does not make recommendations based on dental insurance companies. I understand that I am financially responsible for payment of all charges, including charges in excess of my insurance reasonable and customary. I authorize my insurance benefits directly to Advanced Dental Center. I understand that I am responsible for verifying my insurance coverage and understanding the benefits that I have. I also understand that I am responsible for reasonable collection costs and/or attorney fees incurred in the collection of this account. A photocopy of this statement is considered to be as valid as an original. Additionally, I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

The information given today is correct and to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my medical status, medications, and insurance benefits.

Signature: _____ Date: _____

(OVER PLEASE)

GENERAL HEALTH HISTORY

Are you under a physician's care now? Yes No

If Yes, please explain: _____

Name & Address of Physician: _____

Do you smoke or use tobacco in any other form? Yes No

Please list all medications currently taking: _____

Are any of the medications listed above blood thinners or for osteoporosis? Yes No

Are you sensitive or allergic to any of the following? (please circle)

Latex Penicillin Tetracycline Aspirin Dental Anesthetics Jewelry / Metal Other: _____

Have you been hospitalized in the past two years? Yes No

If Yes, please explain: _____

Do you have any mental or physical limitations that might affect our ability to treat you? Yes No

If Yes, please explain: _____

Have you been advised to take an antibiotic before dental treatment? Yes No

If Yes, please explain: _____

Please circle below if you now have or have had any of the following:

AIDS/HIV Positive
Alzheimer's/Dementia
Anemia
Angina/Chest Pains
Arthritis/Gout
Artificial Heart Valve
Artificial Joint: Knee / Hip
Asthma/Other Breathing Prob.
Auto Immune Disease: _____
Blood Disease/Disorder
Blood Transfusion
Breast Feeding Child
Bruise Easily
Cancer
Chemotherapy
Congenital Heart Disorder
Convulsions
Cortisone Medicine
Currently Pregnant Due: _____
Diabetes
Emphysema
Epilepsy/Seizures
Excessive Bleeding
Excessive Thirst
Fainting Spells/Dizziness
Glaucoma
Heart Attack/Trouble
Heart Murmur
Heart Pace Maker
Hepatitis A/Hep B/Hep C
Herpes
High Blood Pressure
Irregular Heartbeat
Kidney Problems
Latex Allergy
Leukemia
Liver Disease
Lung Disease
Mitral Valve Prolapse
Radiation Treatments
Sickle Cell Disease
Sjogrens Syndrome
Stroke
Thyroid Disease
Tuberculosis
Tumors/Growths
Any Other: _____

Please check any of the following that apply to you:

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain/discomfort when chewing
- ☐ Headaches
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Teeth or fillings breaking
- ☐ Bad breath or bad taste in mouth
- ☐ Jaw Joint Pain
- ☐ Dry Mouth

If you could change your teeth/smile, you would:

- ☐ Make it brighter, whiter
- ☐ Make your teeth straighter
- ☐ Close spaces
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover
- ☐ Replace black metal fillings with natural ones

Do you have or have you had any of the following:

- ☐ Dentures
- ☐ Implants
- ☐ Braces
- ☐ Peridontal Disease
- ☐ Partial Dentures
- ☐ Fear/Anxiety of Dental Procedures

Please share the following dates:

Your last cleaning _____ / _____

Your last complete X-rays _____ / _____

Your last oral cancer screening _____ / _____

On a scale of 1 - 10, with 10 being the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

So that we may best meet your needs, please let us know if you have had any problems/concerns in the past at a dental office:

_____

_____