DC | DENTAL GROUP

PATIENT INFORMATION

DATE _____

NAME _____ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE
LAST FIRST M

SS # _____ BIRTHDATE _____
MONTH DAY YEAR

ADDRESS _____
STREET APT. # CITY STATE ZIP

TELEPHONE (HOME) _____ PLACE OF EMPLOYMENT _____
(WORK) _____ ADDRESS _____
(CELL) _____ _____

EMAIL ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE_____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: ☐PATIENT ☐GUARDIAN ☐SPOUSE ☐FATHER ☐MOTHER

INSURANCE INFORMATION

MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS - COMPLETE PRIMARY INSURED
DUAL COVERAGE - ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESONSIBLE PARTY	**SECONDARY INSURED**
LAST FIRST M	LAST FIRST M
STREET CITY STATE ZIP	STREET CITY STATE ZIP
HOME # WORK # FAX#	HOME # WORK # FAX#
BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT	BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT
EMPLOYER DENTAL INS. CO.	EMPLOYER DENTAL INS. CO.
SS# SUBSCRIBER # GROUP #	SS# SUBSCRIBER # GROUP #

EMERGENCY CONTACT

*Outside of Immediate Family Household

Name _____
Address _____
City/State/Zip _____
Telephone _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to aminister such medications and perform such diagnostic, photograhic & therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my medical/dental histories and other information about my dental treatment to third party payors and/or other health profeesionals.

X _____
Patient or Responsible Party

_____
Date State Driver's License #

REFERRAL SOURCE

How did you hear about our office? (Please specify)

_____

METHOD OF PAYMENT

Responsible party currently has an account with this office?
☐ Yes ☐ No

☐ Payment in full at each appointment (CASH)
☐ Payment in full each appt. (☐ VISA ☐ MC ☐ OTHER)
Card # _____ Exp. Date _____
☐ I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE - If I do not pay the entire new balance within _____ days of the monthly billing date, a service charge *will be added* to the account for the current monthly billing period. The service charge will be a periodic rate of _____ % per month (or a minimum charge of $ _____ for a balance under $ _____) which is an annual percentage rate of _____ % applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, along with any collection costs & reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

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Medical Alert:	Condition:	Premedication:	Allergies:	Anesthesia:	Date:

DENTAL INFORMATION

Reason for today's visit _____

Date and event of symptom onset, if applicable _____

Are you currently in pain? ☐ Yes ☐ No If so, please describe: _____

Do you have any dental problems now? ☐ Yes ☐ No If so, please describe: _____

Have you ever had trouble with a previous dental treatment? ☐ Yes ☐ No If so, please describe: _____

Level of anxiety about seeing the dentist: (least) 1 2 3 4 5 (most)

Date of last dental exam _____ Date of last cleaning _____ Date of last full mouth X-rays _____

Procedure(s) done at last dental visit _____

Previous dentist's name _____

City _____ State _____ Phone (___) ___-_____

Why are you changing dentists? _____

How often do you have dental examinations? _____ How often do you brush your teeth? _____

How often do you floss? _____ What type of bristles do you use? ☐ Hard ☐ Medium ☐ Soft

What other dental aids do you use? (Electric toothbrush, toothpick, etc.) _____

Do you require antibiotics before dental treatment?	☐ Yes	☐ No	Do you have frequent headaches?	☐ Yes	☐ No
Do your gums ever bleed?	☐ Yes	☐ No	Do you clench or grind your teeth?	☐ Yes	☐ No
Have you noticed any mouth odors or bad tastes?	☐ Yes	☐ No	Are your teeth sensitive to heat/cold?	☐ Yes	☐ No
Do you bite your lips or cheeks frequently?	☐ Yes	☐ No	Do you still have your wisdom teeth?	☐ Yes	☐ No
Have you ever had:					
Periodontal disease/gum treatment	☐ Yes	☐ No	Discomfort in your jaw joint (TMJ/TMD)	☐ Yes	☐ No
Orthodontics treatment	☐ Yes	☐ No	Your teeth ground or bite adjusted	☐ Yes	☐ No
Oral surgery	☐ Yes	☐ No	Serious injury to the mouth or head	☐ Yes	☐ No
A bite plate or mouth guard	☐ Yes	☐ No			

If yes to any of the previous questions, please describe _____

Is there anything else about your past dental treatment(s) that you would like us to know? _____

MEDICAL INFORMATION

	Yes	No	Don't Know
If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.			
Have you had any of the following diseases or problems?			
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐
Are you now under the care of a physician?	☐	☐	☐

If yes, what is/are the condition(s) being treated? _____

Date of last physical examination: _____

Physician: _____

NAME PHONE

ADDRESS CITY/STATE ZIP

NAME PHONE

ADDRESS CITY/STATE ZIP

	Yes	No	Don't Know
Have you had any serious illness, operation, or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem? _____

	Yes	No	Don't Know
Are you taking or have you recently taken any medicine(s) including non-prescription medicine?	☐	☐	☐

If yes, what medicine(s) are you taking? _____

Prescribed: _____

Over the counter: _____

Vitamins, natural or herbal preparations and/or diet supplements: _____

Are you taking, or have you taken, any diet drugs such Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?	☐	☐	☐
Do you drink alcoholic beverages?	☐	☐	☐

If yes, how much alcohol did you drink in the last 24 hours? _____

In the past week? _____

Are you alcohol and/or drug dependent?	☐	☐	☐

If yes, have you received treatment? (circle one) Yes / No

Do you use drugs or other substances for recreational purposes?	☐	☐	☐

If yes, please list: _____

Frequency of use (daily, weekly, etc.): _____

Number of years of recreational drug use: _____

Do you use tobacco (smoking, snuff, chew)?	☐	☐	☐

If yes, how interested are you in stopping?

PLEASE COMPLETE BOTH SIDES

ALLERGIES

Are you allergic to or have you had a reaction to?	Yes	No	Don't Know
Local anesthetics	❑	❑	❑
Aspirin	❑	❑	❑
Penicillin or other antibiotics	❑	❑	❑
Barbiturates, sedatives, or sleeping pills	❑	❑	❑
Sulfa drugs	❑	❑	❑
Codeine or other narcotics	❑	❑	❑
Latex	❑	❑	❑
Iodine	❑	❑	❑
Hay fever/seasonal	❑	❑	❑
Animals	❑	❑	❑
Food (specify) _____	❑	❑	❑
Other (specify) _____	❑	❑	❑
Metals (specify) _____	❑	❑	❑

To yes responses, specify type of reaction.

_____

_____

_____

	Yes	No	Don't Know
Is there any other relevent family medical history that you feel the doctor should know in order to effectively treat you?	❑	❑	❑

If you answered yes to the above question, please describe.

_____

_____

	Yes	No	Don't Know
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❑	❑	❑

If yes, what antibiotic and dose? _____

Name of physician or dentist*: _____

Phone: _____

WOMEN ONLY

	Yes	No	Don't Know
Are you or could you be pregnant?	❑	❑	❑
Nursing?	❑	❑	❑
Taking birth control pills or hormonal replacement?	❑	❑	❑

Please (X) a response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	Don't Know
Abnormal bleeding	❑	❑	❑
AIDS or HIV infection	❑	❑	❑
Anemia	❑	❑	❑
Arthritis	❑	❑	❑
Rheumatoid arthritis	❑	❑	❑
Artificial Joints? If yes, indicate: _____	❑	❑	❑
Asthma	❑	❑	❑
Blood transfusion. If yes, date: _____	❑	❑	❑
Cancer/Chemotherapy/Radiation Treatment	❑	❑	❑
Cardiovascular disease. If yes, specify below:	❑	❑	❑
____ Angina	____ Heart murmur		
____ Arteriosclerosis	____ High blood pressure		
____ Artificial heart valves	____ Low blood pressure		
____ Congenital heart defects	____ Mitral valve prolapse		
____ Congestive heart failure	____ Pacemaker		
____ Coronary artery disease	____ Rheumatic heart disease/Rheumatic fever		
____ Damaged heart valves			
____ Heart attack			
Chest pain upon exertion	❑	❑	❑
Chronic pain	❑	❑	❑
Disease, drug, or radiation-induced immunosurpression	❑	❑	❑
Diabetes. If yes, specify below:	❑	❑	❑
____ Type I (Insulin dependent) ____ Type II			
Dry Mouth	❑	❑	❑
Eating disorder. If yes, specify: _____	❑	❑	❑
Epilepsy	❑	❑	❑
Fainting spells or seizures	❑	❑	❑
Gastrointestinal disease	❑	❑	❑
G.E. Reflux/persistent *heartburn*	❑	❑	❑
Glaucoma	❑	❑	❑

	Yes	No	Don't Know
Hemophilia	❑	❑	❑
Hepatitis, jaundice or liver disease	❑	❑	❑
Recurrent Infections	❑	❑	❑
If yes, indicate type of infection: _____			
Kidney problems	❑	❑	❑
Mental health disorders. If yes, specify: _____	❑	❑	❑
Malnutrition	❑	❑	❑
Night sweats	❑	❑	❑
Neurological disorders. If yes, specify: _____	❑	❑	❑
Osteoporosis	❑	❑	❑
Persistent swollen glands in neck			
Respiratory problems. If yes, specify below:	❑	❑	❑
____ Emphysema ____ Bronchitis, etc.			
Severe headaches/migraines	❑	❑	❑
Severe or rapid weight loss	❑	❑	❑
Sexually transmitted disease	❑	❑	❑
Sinus trouble	❑	❑	❑
Sleep disorder	❑	❑	❑
Sores or ulcers in the mouth	❑	❑	❑
Stroke	❑	❑	❑
Systemic lupus erythematosus	❑	❑	❑
Tuberculosis	❑	❑	❑
Thyroid problems	❑	❑	❑
Ulcers	❑	❑	❑
Excessive urination	❑	❑	❑

	Yes	No	Don't Know
Do you have any disease, condition, or problem not listed above that you think I should know about?	❑	❑	❑

Please explain: _____

_____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____ _____ _____ _____

SIGNATURE OF PATIENT/LEGAL GUARDIAN DATE SIGNATURE OF DENTIST DATE Patient BP

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated_____and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT SIGNATURE	BP	REVIEWED BY
_____	_____	None ❑	_____	_____	Dr._____
_____	_____	None ❑	_____	_____	Dr._____
_____	_____	None ❑	_____	_____	Dr._____
_____	_____	None ❑	_____	_____	Dr._____
_____	_____	None ❑	_____	_____	Dr._____