Confidential Patient Information

PERSONAL INFORMATION

(Please Print Legibly)

Name: _____ SS#:_____

Address: _____ City: _____

State _____ Zip: _____ Phone: (_____)_____ Cell#: (_____) _____

Work#: (_____)_____ Email _____

Date of Birth:_____ Sex: ____ Marital Status: _____ Spouse Name:_____

If Student, Name of School_____ City/State_____ ☐ FT ☐ PT

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relationship: _____ SSN#_____

Address _____

City: _____ State:_____ Zip:_____

Home: (____) _____ Work (____)_____ Cell: (___)_____

Employer_____

Date of Birth: _____

DENTAL INSURANCE INFORMATION

Primary Insurance Company_____

Insurance Co. Address: _____

Ins Co. Phone: _____ Group #_____ ID# _____

Employee: _____Relationship: _____ SSN#:_____ DOB_____

Employer:_____ Work Phone: (____)_____

Address of Employer:_____City_____State:_____Zip _____

We are happy to bill your secondary for you. If they pay, the payment will come directly to you. You are responsible for anything that your primary insurance does not pay.

Secondary Insurance Company_____

Insurance Co. Address: _____

Ins Co. Phone:_____ Group #_____ ID#_____

Ins Co. Phone: _____ Group #_____ ID#_____

I understand that payment is my obligation regardless of insurance or any other third-party involvement.

Signature: _____ *Date:*_____

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

Yes	No		Yes	No	
___	___	Do your gums bleed when you brush or floss?	___	___	Have you ever had orthodontic (braces) treatment?
___	___	Are your teeth sensitive to cold, hot, sweets or pressure?	___	___	Have you ever had a serious injury to your head or mouth?
___	___	Do you have any clicking, popping or discomfort in the jaw?	___	___	Are you currently experiencing dental pain or discomfort?
___	___	Does food or floss catch between your teeth?	___	___	Is your mouth dry?
___	___	Do you brux or grind your teeth?			

Health Information

Physician Name:_____ Phone: _____

Yes ___ No ___ Are you now under the care of a physician? For what? _____

Yes ___ No ___ Have you been hospitalized within the past 2 years? For what? _____

Yes ___ No ___ Are you currently taking any medications or drugs?

Medicine _____ Condition _____

Medicine _____ Condition _____

Medicine _____ Condition _____

Do you smoke? Yes ____ No _____
How many packs a day? _____

Yes ___ No ___ Are you allergic to any drugs, metal or Latex? What? _____

Joint Replacement. Have you had an orthopedic total joint replacement? ___ Hip ___ Knee ___Other
Date: _____ If yes, have you had any complications? _____

Are you taking or scheduled to begin taking either of medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? Yes ___ No ___

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Yes ___ No ___ Date Treatment began: _____

Women: Are you pregnant? Yes ___ No ___ Nursing? Yes ___ No ____ Taking birth control pills? Yes ___ No ___

Circle any of the following conditions that you have had or now have:

A. AIDS	F. Epilepsy	K. High Blood Pressure	P. Rheumatic Fever
B. Arthritis	G. Glaucoma	L. Jaundice	Q. Sexually Transmitted Diseases
C. Asthma	H. Heart Murmur	M. Kidney Problems	R. Stroke
D. Cancer	I. Heart Problem*	N. Low Blood Pressure	S. Tuberculosis
E. Diabetes Type I or II	J. Hepatitis Type ____	O. Nervous Breakdown/ Psychiatric Therapy	T. Other Diseases*

If you circled either I or T describe condition: _____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize the insurance company indicated on this form to pay to 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 dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____Reviewed By: _____ Date:_____

For office use: Patient Name: _____ Initial Date: _____

Updated: ____________________	Updated: __________________________
Updated: ____________________	Updated: __________________________