

Insurance Information

Primary Insurance

Insurance Company name _____

Phone number _____

Group # (plan, local or policy #) _____

Insurance Company Address _____
Street/PO box City State Zip

Insured's Name _____ Insured's Social Security # _____

Insured's Birth date ____ / ____ / ____ Relation _____

Insured's Employer _____

Employer's Address _____
Street/PO box City State Zip

<u>Coverage</u>		
Dental	yes	no
Medical	yes	no
Orthodontic	yes	no

Secondary Insurance

Insurance Company name _____

Phone number _____

Group # (plan, local or policy #) _____

Insurance Company Address _____
Street/PO box City State Zip

Insured's Name _____ Insured's Social Security # _____

Insured's Birth date ____ / ____ / ____ Relation _____

Insured's Employer _____

Employer's Address _____
Street/PO box City State Zip

<u>Coverage</u>		
Dental	yes	no
Medical	yes	no
Orthodontic	yes	no

Authorizations

I certify that I have read and understand the above information. I have answered the questions to the best of my knowledge. I also realize it is my responsibility to inform this office of any changes in my medical status. I understand providing incorrect information may be dangerous to my health. I authorize the dental staff to perform the necessary dental services I may need.

Signature

patient, parent, or guardian

____ / ____ / ____
today's date

I certify that I am covered by _____
Insurance Company and I assign directly to
Dr. _____

All insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature

Dental History

Why have you come to the dentist today? _____

Are you currently in pain?	Y	N	Do your gums ever bleed while brushing or flossing?	Y	N
Do you require antibiotics before dental treatment?	Y	N	Do they ever itch?	Y	N
Are you aware of any broken teeth or fillings?	Y	N	Have you ever had periodontal disease?	Y	N
Are your teeth sensitive to sweet/sour?	Y	N	Do you have mobility in your teeth?	Y	N
Do you feel pain in any of your teeth?	Y	N	Do you still have your wisdom teeth?	Y	N
Do you have any sores or lumps in or near your mouth?	Y	N	Would you like fresher breath?	Y	N
Have you had any head, neck or jaw injuries?	Y	N	Would you like whiter teeth?	Y	N
Have you ever experienced any of the following problems in your jaw?			<u>Are you happy with the way your smile looks?</u>	Y	N
a) clicking	Y	N	If not, what would you change? _____		
b) Pain (joint, ear, side of face)	Y	N	_____		
c) difficulty opening/ closing	Y	N	How have your previous dental experiences been		
d) difficulty chewing	Y	N	in the past? <i>Excellent</i> <i>Mediocre</i> <i>Frightening/painful</i>		
Do you have frequent headaches?	Y	N	If frightening, what caused it? _____		
Do you have frequent sinus pain or pressure?	Y	N	_____		
Do you clench or grind your teeth?	Y	N	What can we do to help you with this? _____		
Do you bite your lips/ cheeks frequently?	Y	N	_____		
Have you had any orthodontic work?	Y	N	Have you had regular checkups and cleanings?	Y	N
Have you ever had prolonged bleeding following extractions?	Y	N	Last visit date to a dentist _____		
Have you ever had instruction on the correct method of brushing your teeth?	Y	N	What was done at your last visit? _____		
Have you ever had instructions on the care of your gums?	Y	N	_____		
Have you experienced problems associated with previous dental work?	Y	N	If applicable, why have you neglected your dental health so long?		
Your current dental health is Good Fair Poor			<i>Money</i> <i>Time</i> <i>Procrastination</i> <i>Pain/fear</i>		
Do you floss daily?	Y	N	Why did you leave your previous dentist? _____		
Do you brush daily?	Y	N	_____		
Type of bristles on your toothbrush Hard Medium Soft			Have you lost any teeth? _____ If yes, has it ever been		
Do you use anything in addition to brushing and flossing?	Y	N	recommended that they be replaced? Y N		
If so, what? _____			Do any members of you family where dentures? Y N		
How long do you use a toothbrush before replacing it? _____			If so, did they lose them at a young age? Y N		

Medical History

Do you have a personal physician? Y N Physician's name _____

Office Address _____

Phone Number _____ Date of last visit ____ / ____ / ____

Your current physical health is Good Fair Poor

Are you currently under the care of a physician? Y N

Please Explain _____

Do you smoke or use tobacco in any other form? Y N

For Women

Are you currently taking birth control pills? Yes No

Are you pregnant? Unsure Yes No

Week # _____

Are you nursing? Yes No

Medical History cont'd

Allergies

Aspirin	Y	N
Acrylic	Y	N
Barbiturates	Y	N
Codeine	Y	N
Dental Anesthetics	Y	N
Erythromycin	Y	N
Gluten	Y	N
Jewelry/ Metals	Y	N
Latex	Y	N
Penicillin	Y	N
Sedatives	Y	N
Sulfa Drugs	Y	N
Tetracycline	Y	N
Other	Y	N

If other, please list _____

Medications you are currently taking

Acetaminophen	Y	N
Antibiotics	Y	N
Antihistamines	Y	N
Aspirin	Y	N
Blood Thinners	Y	N
Blood Pressure Medicine	Y	N
Cold Remedies	Y	N
Digitalis/ Heart Medication	Y	N
Insulin/ Diabetes Drugs	Y	N
Nitroglycerin	Y	N
Recreational Drugs	Y	N
Steroids/ Cortisone	Y	N
Thyroid Medicine	Y	N
Tranquilizers	Y	N
Other	Y	N

If other, please list _____

Have you ever taken Phen-Fen? Also known as Redux or Pondimin. Yes No

Have you taken any of the following for bone density? (please circle)

Actonel (risedronate)	Boniva (ibandronate)	Fosamax (alendronate)	Skelid (Tiludronate)
Didronel (Etidronate)	Aredia (pamidronate)	Zometa (zoledronic acid)	Bonefos (Clodronate)

Do you or have you experienced the following?

Angina	Y	N	Glaucoma	Y	N	Persistent Cough	Y	N
Abnormal Bleeding	Y	N	Hay Fever	Y	N	Psychiatric Problems	Y	N
Alcohol Abuse	Y	N	Headaches	Y	N	Radiation Treatment	Y	N
Anemia	Y	N	Heart Attack	Y	N	Recent Weight Loss	Y	N
Arthritis	Y	N	Heart Disease	Y	N	Respiratory Problems	Y	N
Artificial bones/ joints	Y	N	Heart Murmur	Y	N	Rheumatic Fever	Y	N
Artificial valves	Y	N	Heart Surgery	Y	N	Scarlet Fever	Y	N
Asthma	Y	N	Hemophilia	Y	N	Seizures	Y	N
Blood Transfusion	Y	N	Hepatitis	Y	N	Sexually Transmitted Disease	Y	N
Cancer	Y	N	Herpes	Y	N	Shingles	Y	N
Chest Pains	Y	N	High Blood Pressure	Y	N	Sickle Cell Disease	Y	N
Chemotherapy	Y	N	HIV+/ AIDS	Y	N	Sinus Problems	Y	N
Chicken Pox	Y	N	Hospitalized for any reason	Y	N	Steroid Therapy	Y	N
Colitis	Y	N	Joint Replacement/implant	Y	N	Stomach Troubles	Y	N
Congenital Heart Defect	Y	N	Kidney Problems	Y	N	Stroke	Y	N
Diabetes	Y	N	Leukemia	Y	N	Swollen Ankles	Y	N
Difficulty Breathing	Y	N	Liver Disease	Y	N	Thyroid Problems	Y	N
Drug Abuse	Y	N	Low Blood Pressure	Y	N	Tonsillitis	Y	N
Emphysema	Y	N	Lupus	Y	N	Tuberculosis (TB)	Y	N
Epilepsy	Y	N	Mitral Valve Prolapse	Y	N	Ulcers	Y	N
Fever Blisters	Y	N	Pacemaker	Y	N	Venereal Disease	Y	N
Frequently Tired	Y	N						

Any other complications not stated above, please list _____

Any other comments you may have _____

