Welcome to Our Practice!

small DDS FAMILY DENTISTRY

TODAY'S DATE

1 PATIENT INFORMATION

LEGAL NAME (LAST, FIRST, MI) | PREFERRED NAME | CELL PHONE

EMAIL ADDRESS | SOCIAL SECURITY # | BIRTHDATE | AGE

ADDRESS | CITY | STATE / ZIP

GENDER | Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

PATIENT EMPLOYED BY | OCCUPATION | BUSINESS ADDRESS | BUSINESS PHONE

SPOUSE'S NAME | SPOUSE'S OCCUPATION | SPOUSE EMPLOYED BY | SPOUSE'S BUSINESS PHONE

PREVIOUS DENTIST | PHYSICIAN'S NAME | WHO MAY WE THANK FOR REFERRING YOU?

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? | RELATIONSHIP | PHONE

2 PRIMARY DENTAL INSURANCE

INSURED PERSON'S NAME (LAST, FIRST, MI) | RELATION TO PATIENT | BIRTHDATE

ADDRESS (IF DIFFERENT FROM PATIENT'S) | CITY | STATE / ZIP

PHONE | INSURED PERSON'S SOCIAL SECURITY # | GROUP NUMBER

INSURANCE COMPANY | INSURED PERSON'S EMPLOYED BY | OCCUPATION

BUSINESS ADDRESS | BUSINESS PHONE

3 ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

SUBSCRIBER NAME | RELATION TO PATIENT | BIRTHDATE

ADDRESS (IF DIFFERENT FROM PATIENT'S) | CITY | STATE / ZIP

PHONE | SUBSCRIBER'S SOCIAL SECURITY # | GROUP NUMBER

INSURANCE COMPANY | SUBSCRIBER EMPLOYED BY | BUSINESS PHONE

4 RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)

NAME | RELATIONSHIP | PHONE

ADDRESS

5 CONSENTS & PRACTICE POLICIES

I acknowledge receipt of the practice's Notice of Privacy Practices and authorize the dentist and clinical team to perform examinations, diagnostic procedures (including x-rays, photographs, scans, and models), and the treatment, medication, or therapy discussed with me. I understand that dental procedures and anesthesia involve risks, benefits, and possible complications, and I have had the opportunity to ask questions. I understand that payment is due at the time of service, insurance estimates are not guarantees of payment, and I am responsible for any balance not covered by insurance. Balances unpaid after 60 days may accrue a 1.5% monthly finance charge (18% annually), and unpaid accounts may be referred for collection, with reasonable collection costs and attorney fees my responsibility as permitted by law. I authorize the practice to submit insurance claims, release necessary information for payment and care coordination, and use clinical images for my dental record and professional education without identifying information. I understand appointments require at least 24 hours' notice to reschedule, and late cancellations or missed appointments may result in a fee not covered by insurance. I consent to receive appointment reminders and account-related communications by phone, text, email, or automated message and may withdraw this consent in writing.

By signing below, I confirm I have read the statement above and give my consent as described.

PATIENT OR RESPONSIBLE PARTY SIGNATURE | DATE

Health History

6 MEDICAL HISTORY

DATE OF LAST PHYSICAL EXAM

Are you in good physical health? ☐ Yes ☐ No

Are you currently under a physician's care? ☐ Yes ☐ No

IF YES, PLEASE DESCRIBE

Have you had any serious illnesses, operations, or hospitalizations? ☐ Yes ☐ No

IF YES, PLEASE DESCRIBE

Do you smoke or use tobacco, or have you used recreational drugs? ☐ Yes ☐ No

IF YES, PLEASE DESCRIBE

Are you currently taking, or have you ever taken, Bisphosphonates (e.g., Fosamax)? ☐ Yes ☐ No

Please check any conditions you have or have had:

- ☐ AIDS / HIV Positive
- ☐ Anemia
- ☐ Arthritis / Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma or Hay Fever
- ☐ Back Problems
- ☐ Blood Diseases
- ☐ Cancer
- ☐ Cardiac Pacemaker
- ☐ Persistent Cough
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting Spells or Seizures
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis / Jaundice / Liver Disease
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Organ Transplants
- ☐ Osteoporosis
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease

PLEASE DESCRIBE ANY CONDITIONS CHECKED ABOVE

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

Check if you have any of the following allergies:

- ☐ Codeine
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Sulfa
- ☐ Seasonal
- ☐ Local Anesthetic
- ☐ Latex
- ☐ Specific Metals

OTHER ALLERGIES

7 DENTAL HISTORY

REASON FOR TODAY'S VISIT

DATE OF LAST EXAM & X-RAYS

DATE OF LAST CLEANING

Are any of your teeth currently sensitive to:

- ☐ Hot
- ☐ Cold
- ☐ Biting
- ☐ Sweets

Check if you've had problems with any of the following:

- ☐ Bad Breath
- ☐ Food Collection Between Teeth
- ☐ Jaw Locking or Cracking
- ☐ Sores or Growths in the Mouth
- ☐ Bleeding Gums
- ☐ Grinding Teeth
- ☐ Pain in the Ear Region
- ☐ Swelling

Please check any that apply:

- ☐ Nail Biting
- ☐ Mouth Breathing
- ☐ Biting Hard Objects
- ☐ Chewing Ice
- ☐ Hard Swallowing
- ☐ Gags Easily
- ☐ Snores
- ☐ Satisfied with Appearance of Teeth

HOW OFTEN DO YOU BRUSH?

HOW OFTEN DO YOU FLOSS?

DOCTOR'S SIGNATURE

DATE

8 MEDICAL HISTORY UPDATE (TO BE COMPLETED AT FUTURE APPOINTMENTS)

DATE	DATE	DATE	DATE	DATE	DATE
CHANGES	CHANGES	CHANGES	CHANGES	CHANGES	CHANGES
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
INITIALS	INITIALS	INITIALS	INITIALS	INITIALS	INITIALS