ADULT PATIENT INFORMATION

Date _____

Patient's Name _____
LAST FIRST MIDDLE

Residence _____
STREET CITY ZIP

Mailing Address _____
STREET CITY ZIP

Previous Address (If less than 3 years) _____

Home Phone _____ Work Phone _____ Cell Phone _____

Birth Date _____ Email Address _____

Social Security # _____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employer _____ Occupation _____ Years Employed _____

Spouse's Name _____ Cell Phone _____

Employer _____ Occupation _____

Years Employed _____ Social Security # _____ Birth Date _____

Whom may we thank for referring you to our office? _____

DENTAL INSURANCE INFORMATION

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

Insurance Company _____ Group # _____ Local # _____

Insurance Co. Address _____

Phone _____ Do you have dual coverage? ☐ Yes ☐ No If yes:

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

Insurance Company _____ Group # _____ Local # _____

Insurance Co. Address _____

Phone _____

EMERGENCY INFORMATION

Emergency Contact _____

Relationship to Patient _____ Phone _____

Address _____
STREET CITY ZIP

I understand that, where appropriate, credit bureau reports may be obtained.

Signature: _____

Updates (Date & Initial): _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____

Address _____ Phone _____

Please check Yes or No (If Yes, please fill in details)

☐ Yes ☐ No Are you taking any medication? _____

☐ Yes ☐ No Are you allergic to any medication? _____

☐ Yes ☐ No Do you have a history of a major illness? _____

☐ Yes ☐ No Have you had any operations? _____

☐ Yes ☐ No Have you ever been involved in a serious accident? _____

☐ Yes ☐ No Have you ever smoked or chewed tobacco? _____

☐ Yes ☐ No Have seen a physician in the last 12 months? Why? _____

Female patients only:

☐ Yes ☐ No Are you pregnant? _____

☐ Yes ☐ No Has menstruation started? _____

Check any of the medical conditions below that you have had or currently have:

☐ Abnormal bleeding	☐ Herpes	☐ Hay-fever	☐ Kidney problems
☐ Hemophilia	☐ Prolonged bleeding	☐ Gastrointestinal disorders	☐ Tuberculosis
☐ Diabetes	☐ Arthritis	☐ HIV	☐ Congenital Heart Defect
☐ Hepatitis/Liver problems	☐ Epilepsy	☐ Aids	☐ Heart murmur
☐ Pneumonia	☐ High blood pressure	☐ Rheumatic Fever	☐ Nervous disorders
☐ Anemia	☐ Radiation/Chemotherapy	☐ Bone disorders	☐ Tumor / Cancer
☐ Dizziness	☐ Asthma	☐ Heart problems	☐ Other

Are there any other medical conditions we have not discussed that you feel we should be aware of? _____

_____

Signature: _____ Date: _____

DENTAL HISTORY

General Dentist _____ Date of last visit _____

What concerns you most about your teeth? _____

☐ Yes ☐ No Are you presently in any dental pain? _____

☐ Yes ☐ No Have you ever experienced any unfavorable reaction to dentistry? _____

☐ Yes ☐ No Have your wisdom teeth been removed? _____

☐ Yes ☐ No Have you ever lost or chipped any teeth? _____

☐ Yes ☐ No Have there been any injuries to face, mouth, or teeth? _____

☐ Yes ☐ No No Is any part of your mouth sensitive to temperature? Where? _____

☐ Yes ☐ No Is any part of your mouth sensitive to pressure? Where? _____

☐ Yes ☐ No Do your gums bleed when you brush? _____

☐ Yes ☐ No Do you have any type of thumb or tongue habit? _____

☐ Yes ☐ No Are you a mouth breather? _____

☐ Yes ☐ No Have you ever seen an orthodontist? If yes, who and when? _____

☐ Yes ☐ No What is your attitude toward receiving orthodontic treatment? _____

☐ Yes ☐ No Has anyone in your family received orthodontic treatment? _____

How did they feel about the result? _____

☐ Yes ☐ No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____

☐ Yes ☐ No Are you aware of your jaw clicking or popping? _____

☐ Yes ☐ No Are you aware of clenching your teeth during the day? _____

☐ Yes ☐ No Have you ever been told that you grind your teeth? _____

☐ Yes ☐ No Do you have “tension” headaches? _____

☐ Yes ☐ No Have you ever experienced chronic ringing in your ears? _____

☐ Yes ☐ No Are you aware that some appointments will be during work hours? _____

Signature: _____ Date: _____

ENDODONTIC PATIENT REGISTRATION INFORMATION

Welcome to our practice! Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We are happy to help!

Date _____

Name _____ Birth Date _____
FIRST MIDDLE LAST

Address _____
STREET CITY STATE ZIP

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ Social Security # _____

Drivers License # _____ Are you: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Your(or Parent/Guardian's) employer _____ Occupation _____

Business Address _____
STREET CITY STATE ZIP

Emergency Contact _____ Phone _____

Responsible Party: ☐ Same as above

Name of person for this account _____ Relationship _____

Address _____
STREET CITY STATE ZIP

Home Phone _____ Work Phone _____ Cell Phone _____

Birth Date _____ Social Security # _____ Drivers License # _____

Employer _____ Occupation _____

Is this person currently a patient in our office? ☐ Yes ☐ No

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payers and/or other health practitioners.
I authorize and hereby request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on the behalf of my dependents.

_____ _____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR DATE

Late Charges: *If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1% on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in your being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.*

ENDODONTIC REFERRAL FORM

Patient Information

Date _____

First Name _____

Last Name _____

Home Phone _____

Cell Phone _____

Referring Doctor Information

Referred By _____

Phone _____

Email _____

Referred For The Following:

☐ Consultation & Diagnosis

☐ Root Canal Treatment

☐ Re-Treatment

☐ Leave Post Space

☐ Apicoectomy / Retrograde

☐ Pulp Exposure

☐ Remove Post

Radiographs:

☐ Being mailed

☐ Given to patient

☐ Please take

☐ No x-ray

Other Information:

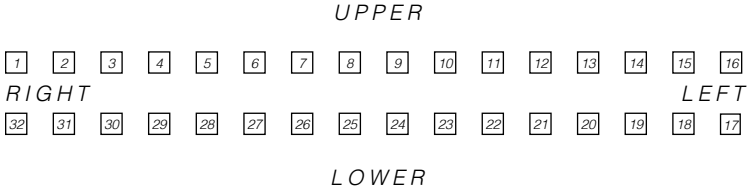
☐ Please send additional referral pads

☐ Please call patient to arrange appointment

☐ Patient will call you to arrange appointment

☐ Crown / Bridge is Cemented (☐ Temporarily ☐ Permanent)

Please Mark Teeth or Area to be Treated:



Remarks or Special Instructions:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____