

Family Dental Care Center

Welcome

Date _____

PATIENT INFORMATION

Name _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____

Cell _____ Can we text you to confirm appointments? Yes No

Email _____ Can we email you? Yes No

Date of Birth _____ Age _____ Sex M F

Patient's Information (unless child, then parent's information)

Social Security # _____

Employer _____

Employer's Address _____

Work Phone _____

Spouse's Name _____

Spouse's Birthdate _____

Spouse's Employer _____

Spouse's Social Security # _____

Whom may we thank for referring you? _____

EMERGENCY CONTACT (please specify someone who does not live in your household)

Name _____ Relationship _____

Home Phone _____ Work Phone _____

HEALTH HISTORY

Physician's Name _____ Physician's Number _____

Please check any of the following that apply to you:

- | | | |
|--|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis-Type_____ | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Herpes | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Bleeding Abnormally | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Swollen Neck Glands |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tumor on head or neck |
| <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervous Problems | Women: <input type="checkbox"/> Pregnant? |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Nursing? |

MEDICATION

Please list any medications you are taking _____

Do you take aspirin? _____ Blood thinner? _____

Any herbal medications? (if yes then list) _____

Caffeine?(if yes list daily intake) _____

ALLERGIES (check all that apply)

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Iodine | <input type="checkbox"/> Penicillin/Amoxicillin |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Latex | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Other _____ |

Reviewed Doctor's Initials _____ Patient's Initials _____

DENTAL HISTORY

Reason for today's visit _____

Former Dentist's Name _____

Street Address _____

City _____ State _____ Zip Code _____

Date of last dental visit _____

What services were performed at that time? _____

Date of last dental x-rays _____

Please check any of the following that apply to you:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Pain around ear |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Sensitivity to cold, hot, sweets |
| <input type="checkbox"/> Blisters on mouth or lips | <input type="checkbox"/> Gums swollen or tender | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Tobacco use | <input type="checkbox"/> Jaw pain or tiredness | <input type="checkbox"/> Sores or growths in mouth |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Loose teeth or broken fillings | |
| <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Orthodontic treatment | |

Check the statement that most applies to you:

1. My mouth is:
Very Comfortable Moderately Comfortable Uncomfortable
2. I think the appearance of my mouth is excellent.
I am satisfied with the appearance of my mouth.
I am dissatisfied with the appearance of my mouth.
3. I think my present state of dental health is:
Excellent Good Poor

What are some questions about dentistry and your oral health that you never had adequately answered? _____

What would you like to change about your smile? _____

Have you had a bad experience in a dental office in the past? _____

What can we do to make your visit today more comfortable? _____

FINANCIAL INFORMATION

Who is responsible for this account? _____ Relationship to patient _____

Address(if different from patient) _____

INSURANCE INFORMATION

Insurance Co Name _____

Ins Co Address _____

Ins Co Phone # _____ Group # _____

Subscriber's Name _____ Subscriber's Birthdate _____

Subscriber's Address(if different from above) _____

Subscriber's Social Security # _____ Relationship to Patient _____

CONSENT

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care. My consent to disclosure or records shall be effective until I revoke it in writing. I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental benefits may pay less than the actual bill for services and that I am financially responsible for payment in full of all accounts. If my account remains unpaid after 90 days, I can be assessed with additional account charges at the rate of 1.5% per month (18% annually). If an office appointment is canceled with less than 24 hours notice, I can be assessed with a cancellation charge of \$50. If the bank returns my check I can be assessed with a processing charge of \$20. I understand that where appropriate, credit bureau reports may be obtained. I attest to the accuracy of the information on this page.

To Our Valued Patients,

All copayments are due at the time of service. We try to estimate your copayments as accurately as possible. However, because there are thousands of individual policies written by each insurance company, we may have underestimated this copayment at the time of your services. If we have underestimated your copayment you will receive a bill from us indicating your further responsibilities per your insurance contract.

The precise amount owed can be found on your insurance company's Estimate of Benefits (E.O.B.) that was mailed to your home address or via their online services. If you did not receive this or do not understand their explanation, please contact the member services department of your insurance company.

If you are concerned about our estimation, we can send a predetermination in advance of your treatment. This will delay your treatment 2-4 weeks, or until we receive a reply from your insurance company. **Please note: Even with a predetermination your insurance company may reserve the right to change the amount paid as specified on the predetermination. This means that even if a predetermination is received and the work is done in accordance with this, the insurance company may not pay to the stated amount and you will be held for any underpayment.**

Patient of Responsible Party Signature _____ Date _____

Doctor Signature _____ Date _____