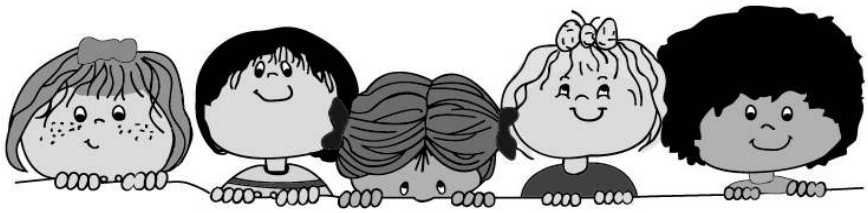
E-mail: _____



CHILDREN'S DENTAL HEALTH CENTER

1 ABOUT YOU

Today's Date _____/_____/_____ File # _____

Patients Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ ❑ Male ❑ Female

Birthdate: ___/___/___ Age: _____ SS#: _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone #: (_____) _____

Work Phone #: (_____) _____ Ext: _____

Cell Phone #: (_____) _____

E-mail: _____

Referred by: _____

Employer: _____ How Long? _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: _____

Do You have children? ❑ No ❑ Yes How many? _____

2 INSURANCE INFO

Primary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: (_____) _____

Insured's ID#: _____

Group #: (Plan, Local or Policy #) _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/_____/____

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: (_____) _____

Insured's ID#: _____

Group #: (Plan, Local or Policy #) _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/_____/_____

Insured's Employer: _____

3 ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____
CITY STATE ZIP

SS #: _____

Drivers License #: _____

Work Phone #: (_____) _____

Payment Method: ❑ Cash ❑ Check

_____ ___/___
❑ Credit Card - Enter card # above (if accepted)

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
Initials

4 EMERGENCY CONTACT

Whom should we contact? _____

Relation: _____

Home Phone #: (_____) _____

Work Phone #: (_____) _____

Cell Phone #: (_____) _____

Who is your Medical Doctor? _____

Medical Doctor's Phone #: (_____) _____

CONTINUE ON BACK

5 DENTAL INFORMATION

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation Are you in pain? ❑ No ❑ Yes How Long? _____

Please check all problems you are experiencing:

❑ Discomfort, clicking or popping in jaw ❑ Lost/Broken filling(s) ❑ Stained teeth ❑ Broken/Chipped tooth
❑ Blisters/Sores in or around mouth ❑ Teeth grinding ❑ Locking Jaw ❑ Sensitive tooth, teeth or gums
❑ Red, swollen or bleeding gums ❑ Ringing in ears ❑ Bad breath ❑ Active Decay/Cavity(ies)
❑ Other: _____

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know Have you ever been treated for Gum Disease? ❑ Yes ❑ No

Previous Dentist: _____ (_____) _____
Name Address Phone #

Last Dental Exam: _____/_____/_____ Last Dental X-rays: _____/_____/_____ Last Dental Cleaning: _____/_____/_____

Have you had problems with previous dental treatment? If so, explain: _____

Times a day you brush? _____ Times a week you floss? _____ Type of toothbrush bristles? ❑ Soft ❑ Medium ❑ Hard

Rate your Smile from 1 - 10: _____ (EXCELLENT=10) Would you like whiter teeth? ❑ Y ❑ N Have you had orthodontic treatment? ❑ Y ❑ N

Things you would change about your smile? _____

6 MEDICAL HISTORY & INFORMATION

What medication are you taking? ❑ Nerve Pills ❑ Pain killers *(including aspirin)* ❑ Muscle relaxer ❑ Stimulants
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Meds for Osteoporosis ❑ Vitamins /Supplements _____
❑ Other(s), please list: _____

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) ❑ Yes ❑ No Phen-fen/Redux ❑ Yes ❑ No

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Murmur	**Y N** Heart Attack/Stroke	**Y N** Heart Surg./Pacemaker	**Y N** Heart Disease/Angina	**Y N** Shingles
Y N Lung Disease	**Y N** Thyroid Problems	**Y N** Congenital Heart Defect	**Y N** Cancer/Tumor(s)/Growth(s)	**Y N** Hepatitis
Y N Liver Problems	**Y N** Seizures/Epilepsy	**Y N** Artificial Heart Valves	**Y N** Chemotherapy/Radiation	**Y N** Glaucoma
Y N Blood Disease	**Y N** Venereal Disease	**Y N** Mitral Valve Prolapse	**Y N** X-ray or Cobalt Treatment	**Y N** Arthritis/Gout
Y N Kidney Problems	**Y N** Cosmetic Surgery	**Y N** G.I. Problems/Ulcers	**Y N** Frequent Thirst/Urination	**Y N** Leukemia
Y N Scarlet Fever	**Y N** Dizziness/Fainting	**Y N** Emphysema/Asthma	**Y N** Bleeding Problems/Anemia	**Y N** Chest Pains
Y N Tuberculosis TB	**Y N** Cold/Fever Blisters	**Y N** Diabetes/Hypoglycemia	**Y N** High/Low Blood Pressure	**Y N** Bruise Easily
Y N HIV+/ AIDS/ARC	**Y N** Blood Transfusion	**Y N** Psychiatric Problems	**Y N** Artificial Bones/Joints/Implants	**Y N** Allergies
Y N Rheumatic Fever	**Y N** Alcohol/Drug Abuse	**Y N** Back/Neck Problems	**Y N** Severe/Frequent Headaches	**Y N** Nervousness
Y N Sinus Problems	**Y N** Eating Disorder	**Y N** Respiratory Problems	**Y N** Jaw Problems TMJ/TMD	**Y N** Sleep Apnea

Please list any other surgeries or medical conditions you have or ever had: _____

_____

Are you allergic to any of the following? ❑ Latex ❑ Penicillin/Amoxicillin ❑ Tetracycline ❑ Aspirin ❑ Codeine
❑ Dental Anesthetics ❑ Foods: _____ ❑ Others: _____

Do you use tobacco? ❑ No ❑ Yes/ How used? _____ How much? _____ How long? _____

Please rate your general health from 1 - 10: _____ Do you wear contact lenses? ❑ Yes ❑ No

For women: Are you taking Birth Control pills? ❑ Yes ❑ No Are you taking hormonal replacement? ❑ Yes ❑ No

Are you pregnant? ❑ No ❑ Yes/How far long? _____ Are you nursing?❑Yes ❑No How many children have you had? _____

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between the provider and patient.
- Our Policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____ **I acknowledge that I have received a copy of the Summary of Privacy Notice.**
Initials

Signature _____ Date _____/_____/_____
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE
(OFFICE USE)

_____ ___/_____/___
Initials **Date**

_____
Comments

_____ ___/_____/___
Initials **Date**

_____
Comments

_____ ___/_____/___
Initials **Date**

_____
Comments

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UPDATE
(OFFICE USE)

_____ ____/____/____
Initials Date

_____
Comments

_____ ____/____/____
Initials Date

_____
Comments

_____ ____/____/____
Initials Date

_____
Comments