Dentistry @the ten

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First Name:_____ Last Name:_____ Middle Initial:_____

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

Address:_____

City:_____ State / Zip_____

Home Phone:_____ Work Phone:_____ Ext:_____ Cellular:_____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed Spouse's Name:_____

Pts Birth Date:_____ Age_____ Soc Sec:_____ Driver's Lic:_____

Email:_____ Prefer to be contacted at: ○ Home Phone ○ Cell Phone ○ Work Phone

Employer:_____

Student Status: ○ Full Time ○ Part Time School Attending:_____

Responsible Party (if someone other than patient)

First Name:_____ Last Name:_____ Middle Initial:_____

Address:_____

City:_____ State / Zip_____

Home Phone:_____ Work Phone:_____ Ext:_____ Cellular:_____

Birth Date:_____ Soc Sec:_____ Driver's Lic:_____

Primary Insurance Information

Name of Insured:_____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured ID#:_____ Insured Birth Date:_____ Group#:_____

Employer:_____ Ins. Company:_____

Insured's Address (if different than pt): Address:_____

_____ Address 2:_____

_____ City, State, Zip:_____

_____ Ins. Co. Phone#:_____

Secondary Insurance Information

Name of Insured:_____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured ID#:_____ Insured Birth Date:_____ Group#:_____

Employer:_____ Ins. Company:_____

Insured's Address (if different than pt): Address:_____

_____ Address 2:_____

_____ City, State, Zip:_____

_____ Ins. Co. Phone#:_____

NOTE: We bill the insurance company as a convenience to the patient. Insurance coverage quoted is only an estimation based on information provided. Guarantor is responsible for all treatment not covered by insurance.

Signature:_____ Date:_____

MEDICALHISTORY

Physician's name_____ Phone No. _____
How would you describe your health?_____ Date of last physical _____
Have you been hospitalized or under a physician's care in the last 2 years?_____ For?_____
List any medications you are taking _____
_____
_____
_____
_____

Have you ever had an adverse reaction or allergies to any medication or substance? (Please circle)
Aspirin Valium Sulfa Drugs Penicillin Erythromycin
Codeine Acrylic Metal Latex Local Anesthetics Other _____

Are you under a physician's care now? ○ Yes ○ No If yes, please explain _____
Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain _____
Have you ever had a serious neck injury? ○ Yes ○ No If yes, please explain _____
Have you ever taken Boniva, Fosomax or any other medication containing Bisphosphonates? ○ Yes ○ No
Are you on a special diet? ○ Yes ○ No If yes, please explain _____
Do you use tobacco? ○ Yes ○ No
Do you use controlled substances? ○ Yes ○ No
Women are you: Pregnant/Trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Do you have, or have you had, any of the following?

AIDS/HIV ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatment ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Pre-Med ○ Yes ○ No	Fainting Spells/ Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Asthma ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Breathing Problem ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disese ○ Yes ○ No
Cancer ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Pre-Med ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No		Yellow Jaundice ○ Yes ○ No

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes, please explain _____
Pre-medication required before dental treatment? ○ Yes ○ No
Rx Information_____ Preferred Pharmacy _____

DENTAL HISTORY

Do you have problems getting numb? ○ Yes ○ No Are you interested in whitening your teeth? ○ Yes ○ No

Do you currently have problems with any of the following?

Bleeding gums	Headaches or neck pain	Bad breath	Grinding or clenching of teeth
Unpleasant taste	Sore areas in the mouth	Loose or chipped teeth	Broken teeth
Missing teeth	Teeth sensitive to pressure	Pain when chewing	Hot / cold tooth sensitivity
Jaw(s) clicking or popping	Sweet sensitive teeth	Other	

CANCELLATION POLICY

We require 24-hour notice. Otherwise,a charge will be made for the time reserved for you. If you fail to show up for a second appointment, you will be charged for the cost of the treatment to be rendered. For a failed third appointment, you will be dismissed asa patient.

I hereby authorize this Practice to administer treatment, x-rays, and anesthetics to perform dental procedures as deemed necessary or advisable in the diagnosis and treatment of my dental condition. I realize that I am ultimately responsible for all cost of treatment. I understand the use of anesthetic agents embodies a certain risk. I authorize my insurance benefits to be paid to this Practice and/or my provider of record.

Signature_____ Date _____