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: _____

## MEDICAL HISTORY

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 as a 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 _____