Date: ____________________

Patient Information:

Last Name:______________________ First Name:______________________Middle:________
Address:____Apt #____________
City:________________________ State:______________ Zip code:________________
Mobile Phone:______________ Work Phone:______________ Home Phone:_____________

Preferred Name:____________________________ Gender: ☐ Male ☐ Female
Date of Birth:______/______/_______ AGE:_______ SS#________-______-________

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Student
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

How would you like to receive your appointment reminders? (Check all that apply)
Telephone (☐ Mobile ☐ Work ☐ Home) ☐ Text ☐ Email______________________________

Emergency Contact:

Last Name: ________________________ First Name: ______________________________
Telephone (☐ Mobile ☐ Work ☐ Home) ____
Relationship to Patient: ____

Insurance Information: *Please present your insurance card and photo id to be scanned for our records*

Primary Insurance:	Secondary Insurance:
Subscriber Name: ______________________	Subscriber Name: ______________________
Subscriber ID: ______________________	Subscriber ID: ______________________
Social Security #: ______________________	Social Security #: ______________________
Relationship to Patient: ______________________	Relationship to Patient: ______________________
Employer Name: ______________________	Employer Name: ______________________
Employer Phone: ______________________	Employer Phone: ______________________
Insurance Company: ______________________	Insurance Company: ______________________
Insurance Group #: ______________________	Insurance Group #: ______________________
Insurance Phone: ______________________	Insurance Phone: ______________________

Responsible Party *(if minor):*

Last Name: ________________________ First Name: ______________________________
Address *(if different)*: ____
Phone: ____________________________ Email: ___________________________________

How did you hear about our practice?

☐ Friend/Family ______________________ ☐ Doctor ____________________________
☐ IAOMT ☐ Website ☐ Search Engine ☐ Sign ☐ Other: ____________________________

Signature: ____________________________ Print Name: ___________________________
(Responsible party if under 18)

Last Name: ____________________________ First_________________________ Date: _______________

ALLERGIES:

Are you allergic or sensitive to: ☐No Allergies ☐Penicillin ☐Sulfa Drugs ☐Erythromycin ☐Aspirin ☐NSAID ☐Codeine ☐Local Anesthetics ☐Latex ☐Nuts ☐Coconut ☐Metals _____________________ ☐Other ___________________________

MEDICAL HISTORY:

1. Physician's Name: ____ Phone: ________________________
2. Date of last physical exam: ____
3. Are you currently under the care of a physician? ☐ Yes ☐ No
   If yes, for what reason(s)? ____

4. Please list any **MEDICATIONS** / **VITAMINS** / **HERBALS** / **SUPPLEMENTS** that your are currently taking.

____ ____
____ ____
____ ____
____ ____
____ ____

6. Do you smoke, chew or use E-Cigarettes? ☐ Yes ☐ No

7. Do you have diabetes? ☐ Yes ☐ No Last HbA1c date and level: ______________________________

8. Do you have, or have you ever had:

Condition	Y	N	Condition	Y	N
Heart murmur	☐ Y	☐ N	Bleeding disorders	☐ Y	☐ N
Heart surgery	☐ Y	☐ N	Thyroid problems	☐ Y	☐ N
Heart stint	☐ Y	☐ N	Hepatitis A B C or other liver disease	☐ Y	☐ N
Rheumatic fever	☐ Y	☐ N	Cancer	☐ Y	☐ N
Artificial heart valve / stint	☐ Y	☐ N	Chemotherapy	☐ Y	☐ N
High blood pressure	☐ Y	☐ N	Arthritis	☐ Y	☐ N
Stroke / TIA's	☐ Y	☐ N	Artificial joint replacements	☐ Y	☐ N
Ulcers / GERD	☐ Y	☐ N	HIV positive / AIDS	☐ Y	☐ N
Kidney trouble / Dialysis	☐ Y	☐ N	Chemical dependency	☐ Y	☐ N
TB or lung disease	☐ Y	☐ N	Glaucoma	☐ Y	☐ N
Asthma	☐ Y	☐ N	Treatment with Bisphosphonates?	☐ Y	☐ N
Epilepsy / Seizures	☐ Y	☐ N	For Women:		
Fainting spells / Dizziness	☐ Y	☐ N	Are you pregnant? Due Date: ______________________	☐ Y	☐ N
Anemia	☐ Y	☐ N	Are you nursing?	☐ Y	☐ N
Leukemia	☐ Y	☐ N	Do you take oral contraceptives?	☐ Y	☐ N

9. Do you have any **medical implants** or prosthetic joints? ☐ Cochlear Implant ☐ Pacemaker ☐ Insulin Pump ☐ Joint Replacement ☐ Cardiac Stint

10. Have you had any other serious illness, hospitalization, or accident? ☐Yes ☐No
    If yes, please explain: ______________________________

Staff Use Only/Notes: ______________________________
____

DENTAL HISTORY:

1. Please tell us the reason for your visit today? ______________________________
2. When was your last visit to a dentist? ______________ Reason: ______________________________
3. Were X-Rays taken? ☐ Yes ☐ No ☐ Unknown
4. Do you require **antibiotics before dental treatment?** ☐Yes ☐No
   If yes: Reason for pre-med ______________________________
   Which antibiotic do you usually take? ______________________________
   Preferred **Pharmacy:** ______________________________ **Phone:** ______________________
5. General Dental Health:

Do you brush your teeth daily?	☐ Y	☐ N
Do you floss daily?	☐ Y	☐ N
Are you currently in pain?	☐ Y	☐ N
Are you experiencing any sensitivity?	☐ Y	☐ N
☐ Hot ☐ Cold ☐ Pressure ☐Sweets		
Do your gums ever bleed?	☐ Y	☐ N
Have you ever been diagnosed with periodontal disease?	☐ Y	☐ N
Have you ever been treated for periodontal disease?	☐ Y	☐ N
Are you concerned with bad breath?	☐ Y	☐ N
Are you concerned with grinding or clenching?	☐ Y	☐ N
Do you wear a bite guard?	☐ Y	☐ N
Do you have TMJ	☐ Y	☐ N
Do you smoke, chew tobacco, or use E-Cigarettes?	☐ Y	☐ N

Staff Use Only/Notes: ______________________________
____

AUTHORIZATION:

I have accurately advised my dental care provider of my current health status and any dietary or herbal supplements, medications and/or drugs (including recreational and over the counter) that I am taking or have taken in the last week.

I consent to the release of information concerning my (or my child's) healthcare, treatment or advice to another dental or healthcare professional, for evaluating treatment or for the purpose of administering or filing claims for insurance benefits. I understand that my insurance benefits may pay less than the actual fees for services and that I am responsible for any services not covered by my insurance. I acknowledge that a copy of the office's *Notice of Privacy Practices* has been made available to me.

Signature ______________________________ Print Name ______________________________
(Responsible Party if under 18)

APPOINTMENT GUIDELINES

We welcome you to our practice. We provide the most modern, high tech, and comfortable dentistry combined with compassion and artistry. In order to serve all of our patients, we kindly request:

1. Please notify us, **prior** to seeing the dentist or hygienist of any changes in address, phone numbers, e-mail address, marital status, medical situation, medications taken, or insurance benefits.

2. A **24 hour** notice is required to cancel an appointment. If we are given less than a 24 hour notice, it is considered a **broken appointment**. A broken appointment **will** require us to charge your account half of the charge of the procedure appointed. If you fail to show for your appointment, you will be charged a fee as well.

3. To prevent inconvenience to our "**on time**" guests, "**late**" guests may need to be rescheduled.

4. A parent or guardian must sign for children under the age of 18 years old. The parent or guardian that signs the patient in and/or makes the appointment is responsible for that patient's account regardless of any divorce/court orders.

FINANCIAL ARRANGEMENTS

Dental treatment is an excellent investment in an individual's medical and psychological well being. Financial considerations should not be an obstacle to obtaining this important health service. Being sensitive to the fact that people have different needs in fulfilling their financial obligations, we are providing the following payment information

Payment in Full

We accept cash, personal checks, Visa, MasterCard, Discover and American Express. Payment is expected on the day that services are rendered.

Extended Payment Plans

We also offer extended payments through Care Credit. Please inquire at our front desk for more information.

Insurance Filing Reimbursement

We will be happy to submit your dental claim to your insurance company as a courtesy to you, our valued patient. We are not an In-Network Provider with any insurance company, therefore, some insurance companies will not release payment to our office. If this is true for your insurance, you will be asked to pay in full and we will have your insurance company reimburse you directly.

Signed____**Date**______________________

(Responsible party if under 18 yrs)