



Today's date: _____

E-mail Address: _____

Patient's Name: _____

I prefer to be called: _____ Male Female

Birthdate ___/___/___ Age: ___ Social Security#: _____ Single Married Divorced Widowed Separated

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell#: _____ Work Phone#: _____ Driver's License #: _____

Where & when are best times to reach you? _____ Whom may we thank for referring you? _____

Employer: _____ Address: _____

Spouse: _____

Employer: _____ Address: _____

MEDICAL HISTORY

Do you have a personal physician? Y N

Are you currently under the care of a physician? Yes No

Physician's Name: _____

Please explain: _____

Address: _____

Do you smoke or use tobacco in any form? Yes No

City: _____ State: _____ Zip: _____

Have you ever taken Phen-Fen, Redux or Pondimin? Yes No

Phone: _____

For Women, are you taking birth control pills? Yes No

Date of last visit: _____

Are you pregnant? Unsure? Yes No

Your current physical health is: Good Fair Poor

Week #: _____ Are you nursing? Yes No

Do you or have you experienced the following?

- | | | | | |
|--|--|--|--|--|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Colitis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Headaches | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Lupus | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Steroid Therapy |
| <input type="checkbox"/> Artificial Bones/Joints | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Valves | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Ever Hospitalized | <input type="checkbox"/> Herpes | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> HIV /AIDS | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Seizures | |

Please list any serious medical condition(s) that you have experienced: _____

Are you taking any prescription / over the counter drugs? Yes No If yes, please list each one: _____

Are you allergic to any of the following?

- | | | | | | |
|---------------------------------------|---|---|-------------------------------------|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Latex | <input type="checkbox"/> Sedatives | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Jewelry Metals | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Other |

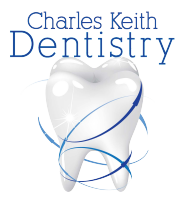
Please list anything additional that causes allergic reactions: _____

Patient's Signature: _____

Doctor's Signature: _____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.



DENTAL HISTORY

Why have you come to the dentist today? _____ Are your teeth sensitive to heat, cold, or anything else?
_____ Do you have mobility in your teeth? Yes No
Are you currently in pain? Yes No Do you still have wisdom teeth? Yes No
Do you require antibiotics before dental treatment? Yes No Previous | Present Dentist: _____ Last Visit Date: _____
(Circle One)
Do you floss daily? Yes No Brush daily? Yes No Would you like fresher breath? Yes No Whiter teeth? Yes No
Type of bristles on your toothbrush? Hard Medium Soft Are you happy with the way your smile looks? Yes No
Do your gums bleed? Yes No Ever Itch? Yes No If not, what would you change? _____
Have you ever had periodontal disease? Yes No _____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance Dental Coverage? Yes No
Insurance Co. Name: _____ Phone#: _____ Group# (Plan, Local or Policy#): _____
Insurance Co. Address: _____
Insured's Name: _____ Insured's S.S.#: _____ Insured's D.O.B.: ___/___/___ Relation: _____
Insured's Employer: _____ Employer's Address: _____

Secondary Dental Insurance Dental Coverage? Yes No
Insurance Co. Name: _____ Phone#: _____ Group# (Plan, Local or Policy#): _____
Insurance Co. Address: _____
Insured's Name: _____ Insured's S.S.#: _____ Insured's D.O.B.: ___/___/___ Relation: _____
Insured's Employer: _____ Employer's Address: _____

PAYMENT POLICY

Our policy is to require payment at the time services are provided.

We attempt to remain informed about our patients insurance plans; however, due to the enormous number of such plans, it is impossible for us to determine the exact benefits which each individual plan might pay; therefore, we rely on you to be knowledgeable about your insurance plan and the coverage and benefits it provides. Please note: By filing a claim on your insurance, we do not guarantee the insurance coverage or benefits paid, nor can we accept responsibility for any amounts which your insurance company may not pay. Written or verbal estimates given by our office are not a guarantee of payment. Amounts filed on your insurance are your responsibility, if for any reason a claim is not fully paid by your insurance, the remaining unpaid balance will become due from you, and payable at that time. Generally, we allow 30 days for claims to be paid by your insurance company.

Our fees are considered standard with other general dentists in the Mobile area. In giving you the care that you need and deserve, we do attempt to keep your cost to a minimum Emergencies and insurance reimbursement are handled on an individual basis: please feel free to discuss financial matters with the office manager.

I have read and understand the payment policy above, and agree to comply accordingly.

I, _____, have received a copy of this office's Notice of Privacy Practices.

SUBMIT FORM