ADULT PATIENT INFORMATION

Please complete the **FRONT** and **BACK** of this form in black or blue ink and return to the receptionist. Thank you!

Personal Information

Today's Date: _____

Name: _____ Birth date: _____ Sex: Male Female

Preferred Name: _____ Age: _____ Marital Status: Married Single Other

Address: _____ Spouse's Name: _____ No. of Children: _____

_____ Your Social Security No.: _____

City State Zip

Your Driver's License No: _____

Home Phone ( ) _____ Work Phone ( ) _____

Employer: _____

Cell Phone ( ) _____ Other Phone ( ) _____

Employer's Address: _____

_____

Head of Household: _____ City State Zip

(This is for billing purposes. Party responsible for family account)

In Case of Emergency, Contact: _____ Contact Phone #: _____

Contact Relationship to Patient: _____

E-mail and Confirming Appointments

May we have your email address in order to send you appointment reminders or a message from the doctor? YES NO

If yes, please list your e-mail address: _____

Medical/Dental Information

Name of Family Physician: _____ How is your health? Excellent Good Fair Poor

Physician's Address: _____ Physician's Phone No.: _____

Previous Dentist's Name: _____ Previous Dentist's Phone No.: _____

Do you have, or have you ever had, ANY of the following?

	Yes	No		Yes	No
Artificial heart valve	☐	☐	Nervous Disorders	☐	☐
Artificial joints	☐	☐	Radiation treatment	☐	☐
Heart Disease/Heart Attack	☐	☐	Liver Disease	☐	☐
Repaired Congenital heart defect	☐	☐	Kidney Disease	☐	☐
High Blood Pressure	☐	☐	Hepatitis	☐	☐
Blood Disease	☐	☐	Asthma/Respiratory Problems	☐	☐
Rheumatic Fever	☐	☐	Tuberculosis	☐	☐
Endocarditis	☐	☐	AIDS or HIV Positive	☐	☐
Diabetes	☐	☐	Alcoholism	☐	☐
Stroke	☐	☐	Drug Addiction	☐	☐
Epilepsy/Seizures	☐	☐	Medication Allergies: _____	☐	☐
Arthritis/Rheumatoid Arthritis	☐	☐	Other Allergies (latex, metals, etc):_____	☐	☐
Cancer or Tumor History	☐	☐	TMJ/Jaw Joint Problems	☐	☐
Sexually Transmitted Disease	☐	☐	Do you snore?	☐	☐

Any other Illness: _____

Surgeries: _____

Please answer YES or NO to the Following Questions:

- Are you having any pain or discomfort in or around your mouth at this time?_____ YES NO
- Do you feel nervous about dental treatment? _____ YES NO
- Have you ever been upset about any dental work you have received? _____ YES NO
- Have you changed dentists frequently? If yes, how often? _____ YES NO
- Have you been a patient in the hospital during the last two years? _____ YES NO
- Are you currently under the care of a physician? _____ YES NO
- Are you currently taking any medications? If yes, specify. _____ YES NO
- Have you ever had any excessive bleeding requiring special treatment? _____ YES NO
- Have you ever experienced growths or sore spots in your mouth?_____ YES NO
- Have you had any allergic reactions or allergic symptoms to local or general anesthetics? _____ YES NO
- Have you ever had difficulty with extractions in the past? _____ YES NO
- Do your gums bleed with you brush or floss? _____ YES NO
- Do you habitually clench or grind your teeth? _____ YES NO
- Do you smoke? _____ YES NO
- Do you have any disease, conditions or allergies not listed? _____ YES NO
- Are you or have you ever taken medications for osteoporosis, bone density or cancer? (such as Boniva, Fosamax, Reclast, etc.)_____ YES NO

Women Only

- Are you pregnant? _____ YES NO
- Are you practicing birth control? _____ YES NO
- Do you anticipate becoming pregnant in the near future? _____ YES NO

Dental Insurance Information

Name of Insurance Company: _____ Phone No.: _____

Name of Policyholder: _____ Policyholder's SSN: _____

Patient's Relationship to Policyholder: Self/Spouse/Child/Other: ____ Policyholder's DOB: _____

Employer's Name Providing Insurance: _____ Group No.: _____

I authorize the assignment of my insurance benefits to DENTAL INNOVATIONS.

Patient's Signature: _____ Date: _____

Referral Information

How were you referred to our office? Please circle all that apply.

Insurance Company
Friend (Please list their name: _____)
Cosmetic Postcard
Dental Office Employee (Please list name: _____)
Other (Please list: _____)
Yellow Pages: JO CO SWB FEIST/Yellow Bk
Internet Ad/Family Dental Website
Walk In
Val-Pak Offer
Drive By

Treatment Authorization and Acknowledgement

I consent to treatment as necessary or desirable to the care of the patient first named above, for the diagnosis of dental disease, or treatment of dental emergency. These procedures may include radiographs, models or intra-oral examination. In case of a dental emergency, I consent to treatment as deemed necessary by the doctor understanding that the procedures will be explained in advance. I give consent to the use of local anesthetic for completing the necessary dental treatment.

I also understand that **PAYMENT IS DUE AT THE TIME OF TREATMENT.**

I HAVE READ AND UNDERSTAND AND AGREE TO THE ABOVE POLICY.

_____ _____

Patient, Parent, or Legal Guardian Date