

INFORMATION PROFILE

The following information is necessary to complete your chart and enable us to best treat your dental needs.

Phone Numbers

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_ Birthdate \_\_\_\_\_
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Email \_\_\_\_\_
Present Employer \_\_\_\_\_
Business Address \_\_\_\_\_
Occupation \_\_\_\_\_

Home \_\_\_\_\_
Office \_\_\_\_\_
Cell \_\_\_\_\_
Pager \_\_\_\_\_
Other \_\_\_\_\_

Name of Spouse \_\_\_\_\_ If patient is child, name of parents \_\_\_\_\_

What is your reason for today's visit? \_\_\_\_\_

Date of last dental visit? \_\_\_\_\_

Have you had a complete set of 18 x-rays within the last 3 years?  YES  NO

Soc. Sec. #patient \_\_\_\_\_ Who will be responsible for paying this account & their Soc. Sec. #? \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Emergency Information

Please give us names, addresses, and phone numbers of two relatives or friends living closest to you:

1) \_\_\_\_\_

2) \_\_\_\_\_

MEDICAL HISTORY

Have you ever been told you need to premedicated before dental treatment?  YES  NO

✓ Check if you have had any of the following:

- A.I.D.S./HIV
 Allergic reactions
 Allergies (latex, metal, Chemicals)
 Anemia
 Arthritis, Rheumatism
 Artificial Heart Valves
 Artificial Joints
 Asthma
 Cancer
 Canker Sores
 Chemical Dependency
 Chemotherapy
 Circulatory Problems
 Cortisone treatments
 Cough, persistent
 Diabetes
 Epilepsy
 Emphysema
 Fainting
 Food Allergies
 Glaucoma
 Frequent Headaches
 Heart Murmur
 Heart Problems
Describe: \_\_\_\_\_
 Hemophilia/Abnormal Bleeding
 Herpes
 Hepatitis Type \_\_\_\_\_
 High Blood Pressure
 Jaw Pain
 Kidney Disease or
 Malfunction
 Liver Disease
 Mitral Valve Prolapse
 Nervous Problems
 Pacemaker/Heart Surgery
 Psychiatric Care
 Rapid Weight Gain or Loss
 Radiation Treatment
 Respiratory Disease
 Rheumatic/Scarlet/fever
 Shingles
 Shortness of Breath
 Skin Rash
 Stroke
 Surgical Implant
 Swelling of Feet or Ankles
 Thyroid Disease or Malfunction
 Tobacco Habit
 Tonsillitis
 Tuberculosis
 Ulcer/Colitis

List medications you are currently taking, if any:

\_\_\_\_\_  
\_\_\_\_\_

List drug allergies, if any:

\_\_\_\_\_  
\_\_\_\_\_

**DENTAL HISTORY**

- |   |   |     |                                      |   |     |
|---|---|-----|--------------------------------------|---|-----|
| 1) Have you ever had a bad experience during previous dental treatment? | <input type="checkbox"/> <input type="checkbox"/> | Y N | Are you happy with your smile?       | <input type="checkbox"/> <input type="checkbox"/> | Y N |
| 2) Does anything hurt in your mouth or is anything not comfortable?     | <input type="checkbox"/> <input type="checkbox"/> |     | If not, what would you change? _____ |   |     |
| 3) Have you been told you have TMJ problems?                            | <input type="checkbox"/> <input type="checkbox"/> |     | _____                                |   |     |

I hereby give permission to the Doctor or his agent to administer treatment and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my dental condition.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Primary Insurance**

A) Person Responsible for Account \_\_\_\_\_

\_\_\_\_\_  
Last Name First Name Initial

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec# \_\_\_\_\_  
(If self skip to part B)

Address (if different from patient) \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

B) Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Contract# \_\_\_\_\_ Group# \_\_\_\_\_ Subscriber# \_\_\_\_\_

Name of other dependents under this plan \_\_\_\_\_

**Additional Insurance**

Is patient covered by additional insurance? Yes No

Subscriber \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_

Address (If different from patient) \_\_\_\_\_ Soc. Sec # \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Subscriber Employed by \_\_\_\_\_ Business Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Contract# \_\_\_\_\_ Group# \_\_\_\_\_ Subscriber# \_\_\_\_\_

Name of other dependents under this plan \_\_\_\_\_

Is there anything you would like to tell us that would help us make your experience here a positive one?

\_\_\_\_\_  
\_\_\_\_\_

**Agreement to Pay**

I have reviewed the information on the questionnaire, and it is accurate to the best of my knowledge, I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been added. In the event payments are not received by the agreed upon dates, I understand that a 1 – ½% finance charge (18% APR) may be added to my account, in addition to any collection charges.

Signature \_\_\_\_\_ Date \_\_\_\_\_