

Welcome to our Practice! Please fill out the following patient information –Thank you.

Name _____
LAST FIRST MIDDLE INITIAL NICKNAME

Address _____
STREET

_____ CITY STATE ZIP

Employer _____ Drivers License _____

Birth date _____ Social Security # _____

Phone #'s Home (_____) _____

Work (_____) _____ Male Female Child

Mobile (_____) _____

Emergency: Name _____ Phone (_____) _____

Insurance

Primary Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Secondary Carrier (Delta Dental Only)

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs incurred from dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

Signature _____ Date _____

Treatment and Payment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the statements regarding my medical condition listed are correct to the best of my knowledge.

Payment for all treatment and services rendered are my responsibility.

PATIENTS SIGNATURE DATE

If patient is a child or requires a guardian:

PARENT/GUARDIAN SIGNATURE DATE

Please turn over and fill out other side- thank you

MODERN FAMILY DENTISTRY
ARIZONA STUDIO *for* SMILE DESIGN

So that we may provide you with the best possible care, please complete the medical/dental history form - Thank-you.

What is the reason for your visit today? _____

Former Dentist _____ Phone _____ Why did you leave your last dentist? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ X-rays _____

How often do you have dental examinations? _____ Cleanings _____

How often do you brush your teeth _____ How often do you floss _____

Are you under the care of a Physician? ____ If so, for what? _____

Name, address and phone number of that physician _____

Are you pregnant? If so, what is your due date? _____ Ob/Gyn Phone # _____

Do you require antibiotics prior to dental treatment? _____ If so what do you take? _____

Are you allergic to any medications? If yes please list _____

Are you taking any medications? If yes please list _____

Medical History and information

Are your teeth sensitive to:	<u>Yes</u>	<u>No</u>	Do you frequently get cold sores, blisters or Any other oral lesions?	<u>Yes</u>	<u>No</u>
Heat?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had:	<input type="checkbox"/>	<input type="checkbox"/>
Cold?	<input type="checkbox"/>	<input type="checkbox"/>	Orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Sweets?	<input type="checkbox"/>	<input type="checkbox"/>	Oral Surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Biting Pressure?	<input type="checkbox"/>	<input type="checkbox"/>	Periodontal/Gum treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Does food catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Deep Cleanings?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when brushing?	<input type="checkbox"/>	<input type="checkbox"/>	A bite plate or mouth guard?	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed any gum swelling around any teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Are you interested in orthodontic treatment for yourself or a family member?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an unpleasant taste or odor in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Problems of the Jaw:			To the best of your knowledge, are you or have you ever been afflicted with:		
Clicking of the jaw	<input type="checkbox"/>	<input type="checkbox"/>	Heart Ailment _____	<input type="checkbox"/>	<input type="checkbox"/>
Pain (joints, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty opening or closing	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty chewing	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever avoid any part of the mouth while brushing?	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a reaction to a local anesthetic?	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Are you dissatisfied with your teeth and their appearance?	<input type="checkbox"/>	<input type="checkbox"/>	HIV+ / AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Are you deeply concerned about the finances required to Achieve excellent dental health?	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Do you get frustrated because you always have something To be treated or repaired when you visit a dentist?	<input type="checkbox"/>	<input type="checkbox"/>	Healing complications	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	Artificial bones /joints /valves	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any teeth removed?	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol/Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>
How long have these teeth been missing? _____	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel you will eventually wear artificial dentures?	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any dental related fears?	<input type="checkbox"/>	<input type="checkbox"/>			