

*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 (\_\_\_\_\_) \_\_\_\_\_  
 Male  Female  Child

Work (\_\_\_\_\_) \_\_\_\_\_

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>                |
|--|--------------------------|--------------------------|
| Heat?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Cold?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Sweets?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Biting Pressure?                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Does food catch between your teeth?                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Do your gums bleed when brushing?                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you noticed any gum swelling around any teeth?    | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have an unpleasant taste or odor in your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |

|   | <u>Yes</u>               | <u>No</u>                |
|---|--------------------------|--------------------------|
| Do you frequently get cold sores, blisters or Any other oral lesions? | <input type="checkbox"/> | <input type="checkbox"/> |

**Have you ever had:**

|  |                          |                          |
|--|--------------------------|--------------------------|
| Orthodontic treatment?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Oral Surgery?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Periodontal/Gum treatment?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Deep Cleanings?  | <input type="checkbox"/> | <input type="checkbox"/> |
| A bite plate or mouth guard?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you interested in orthodontic treatment for yourself or a family member? | <input type="checkbox"/> | <input type="checkbox"/> |

**Problems of the Jaw:**

|                                  |                          |                          |
|----------------------------------|--------------------------|--------------------------|
| Clicking of the jaw              | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain (joints, ear, side of face) | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty opening or closing    | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty chewing               | <input type="checkbox"/> | <input type="checkbox"/> |

**To the best of your knowledge, are you or have you ever been afflicted with:**

|   |                          |                          |                                  |                          |                          |
|---|--------------------------|--------------------------|----------------------------------|--------------------------|--------------------------|
| Do you ever avoid any part of the mouth while brushing?   | <input type="checkbox"/> | <input type="checkbox"/> | Heart Ailment _____              | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had a reaction to a local anesthetic?  | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you dissatisfied with your teeth and their appearance?  | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever                  | <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"/> | Epilepsy                         | <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"/> | High Blood Pressure              | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you smoke?   | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had any teeth removed?  | <input type="checkbox"/> | <input type="checkbox"/> | HIV+ / AIDS                      | <input type="checkbox"/> | <input type="checkbox"/> |
| How long have these teeth been missing? _____   | <input type="checkbox"/> | <input type="checkbox"/> | Prolonged Bleeding               | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you feel you will eventually wear artificial dentures?   | <input type="checkbox"/> | <input type="checkbox"/> | Healing complications            | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any dental related fears?   | <input type="checkbox"/> | <input type="checkbox"/> | Artificial bones /joints /valves | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | Alcohol/Drug Abuse               | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | Asthma                           | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | Pacemaker                        | <input type="checkbox"/> | <input type="checkbox"/> |