Thank you for choosing Dental Associates for your dental needs. We will strive to provide you with the best possible dental care. To help us meet all your dental health needs, please fill out this form completely. If you have any question or need assistance, please ask our friendly front desk staff, we would be happy to assist you.

Welcome to our office…….
We take your smile to heart!

Patient Information (Confidential)

Name_____ Birthday_____ Home Phone_____
Address_____ City/State/Zip_____
Email Address_____ Cell Phone_____
Social Security Number_____ Work Phone_____
Status: Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐
Patient's Employer_____ Occupation_____ Work Number_____

By initialing, you consent to receive SMS text messages from Dental Associates for appointment reminders, marketing messages, and general two-way communication. Message and data rates may apply. Message frequency varies. Reply "HELP" for help and "STOP" to opt out. Refer to our Terms and Conditions and Privacy Policy for more information. We also have permission to reach you via mail, work phone, home phone and email. Initial:_____

Responsible Party

Name of person Responsible for Account_____ Relationship_____
Address_____ Home Phone_____
Work Phone_____ Cell Phone_____ Birthday_____

Insurance Information

Name of Insured_____ Relationship to patient_____
Birthday_____ SS#_____ Employer_____ Work#_____
Name of Insurance Company_____ Policy #_____ Group #_____
Insurance Address_____
City/State/Zip_____ Insurance Phone #_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐YES ☐NO If yes, complete the following:

Name of Insured_____ Relationship to patient_____
Birthday_____ SS#_____ Employer_____ Work#_____
Name of Insurance Company_____ Policy #_____ Group #_____
Insurance Address_____
City/State/Zip_____ Insurance Phone #_____

All co-pays and deductible are to be paid at the **TIME OF THE VISIT.** It is **your responsibility** to know what your insurance covers. Please remember, since dental care is given only by private contract between the doctor and the patient, responsibility for payment is yours alone as you are the person who received the care. **As a courtesy**, we will file your primary insurance claim for you.
I understand that I am responsible for the balance of my dental account regardless of my insurance. My account will incur an 18% APR finance charge if my balance goes beyond 60 days.

I, the undersigned, affirm the information given on this form to be accurate.
I also consent to examination and treatment.

Date:_____ Signature:_____
Parent, if patient is a minor

Signature of Dentist:_____

Turn Over Please

Patient Medical History

1. Who is your Medical Doctor? _____ Doctor's Phone #_____
2. Are you under medical treatment now? ☐Yes ☐No
3. Have you been hospitalized for any surgical operation or serious illness within the last 5 years? ☐Yes ☐No
   If yes, please explain_____
4. Are you taking any medication including non-prescription medicine? ☐Yes ☐No

Name of Medication	Condition being taken for

5. Are you sensitive or allergic to any drugs or medication? ☐Yes ☐No

Name of Medication	Reaction Experienced

6. Do you have or have you had any of the following? If yes, please write the approximate date you first learned of the condition.

Joint Replacement_____	Asthma_____	Epilepsy_____
High Blood Pressure_____	Heart Disease_____	Chest Pains_____
Heart Attack_____	Cardiac Pacemaker_____	Short of Breath_____
Rheumatic Fever_____	Heart Murmur_____	Stroke_____
Allergies_____	Cancer_____	Diabetes_____
Seizures_____	Tuberculosis_____	AIDS/HIV_____
Arthritis_____	Hepatitis_____	Heart Trouble_____
Blood Transfusion_____	Venereal Disease_____	Multiple Sclerosis_____

7. Are you pregnant or nursing? ☐Yes ☐No
8. Have you ever had any excessive bleeding? ☐Yes ☐No
9. Have you had any major surgeries? ☐Yes ☐No If yes, type of surgery_____
10. Do you use tobacco? ☐Yes ☐No
11. Are you allergic to any Metals or jewelry? ☐Yes ☐No

Dental History

1. Are you having any dental discomfort at this time? ☐Yes ☐No
2. Approximate date of last dental treatment_____
3. Have you noticed any of the following:

Grinding or clenching teeth	☐Yes	☐No	Bleeding gums when brushing	☐Yes	☐No
Teeth tender to chew on	☐Yes	☐No	Food catching between teeth	☐Yes	☐No
Teeth sensitive to hot/cold	☐Yes	☐No	Swelling or sores in mouth	☐Yes	☐No

4. Have you ever had a bad reaction to a dental anesthetic? ☐Yes ☐No
5. Have you ever had your teeth straightened? ☐Yes ☐No
6. Have you had any serious trouble associated with previous dental treatment? ☐Yes ☐No
   Please explain_____
7. Do you have any pain or soreness around your eyes or ears or other parts of your face? ☐Yes ☐No
   When_____
8. Do you have "tension" headaches? ☐Yes ☐No

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants. Signature_____