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_____________
Spouse's Name_____________________________ Spouse's Social Security Number___________________
Spouse's Employer_____________________ Occupation_______________ Work Number_____________

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 if 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
10. Are you on birth control pills? ☐Yes ☐No
11. Are you allergic to any Metals or jewelry? ☐Yes ☐No

If yes, type of surgery________________________

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:
   - Finding or clenching teeth ☐Yes ☐No
   - Tenth tender to chew on ☐Yes ☐No
   - Teeth sensitive to hot/cold ☐Yes ☐No
   - Bleeding gums when brushing ☐Yes ☐No
   - Food catching between teeth ☐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________________________