Dental History Form

Page 1

Patients Date of birth

__/__/____

Patient's First Name *

Patient's Last Name *

Are you the patient or are you filling out the forms for them? *

- ○ I am the Patient
- ○ I am filling out for the patient

Dental History Information

Name of your previous dentist

Date of last dental visit

__/__/____

What is the most important thing to you about your dental visit today?

Why did you leave your previous dentist?

Do your gums bleed when you brush?

○ Yes ○ No

Have you ever been treated for periodontal disease?

○ Yes ○ No

Have you ever had complications from a dental procedure?

○ Yes ○ No

Have you ever had a popping or clicking near your ear when you chew?

○ Yes ○ No

Are you prone to frequent headaches?

○ Yes ○ No

Do you grind or clench your teeth?

○ Yes ○ No

Do you have sores, blisters or swelling on your gums lips or cheeks?

○ Yes ○ No

Have you ever had orthodontic treatment?

○ Yes ○ No

Do you snore?

○ Yes ○ No

Do you have problems with bad breath?

○ Yes ○ No

Have you ever had an allergic reaction to a crown, metal filling or dental appliance?

○ Yes ○ No

Are your teeth sensitive to hot, cold or pressure?

○ Yes ○ No

Please mark any of the following conditions that apply to you:

Pain/Discomfort

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Pressure
- ☐ Broken teeth/fillings
- ☐ Worn teeth
- ☐ Dry Mouth

Appearance

- ☐ Discolored teeth
- ☐ Worn teeth
- ☐ Misshaped teeth
- ☐ Crooked teeth
- ☐ Spaces
- ☐ Overbite
- ☐ Flat teeth

Function

- ☐ Grinding/Clenching
- ☐ Headaches
- ☐ Jaw Joint (TMJ) pain
- ☐ Jaw Joint (TMJ) pain/popping
- ☐ Bad Bite
- ☐ Speech Impediment
- ☐ Mouth Breathing
- ☐ Sore Muscles (neck, shoulders)
- ☐ Difficulty Opening or Closing
- ☐ Difficulty Chewing on either side

Periodontal (Gum) Health

- ☐ Bleeding, Swollen, Irritated gums
- ☐ Bad breath
- ☐ Loose tipped, shifting teeth
- ☐ Previous perio/gum disease

Habits

- ☐ Thumb sucking
- ☐ Nail-biting
- ☐ Cheek/Lip biting
- ☐ Chewing on ice/foreign objects

Sleep Pattern or Conditions

- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Daytime Drowsiness
- ☐ Bed wetting (for children)

Previous Comfort Options

- ☐ Nitrous Oxide
- ☐ Oral Sedation (Pill)
- ☐ IV Sedation

Tobacco use

○ Yes ○ No

Alcohol use

○ Yes ○ No

Drug use

○ Yes ○ No

Please list family history of any conditions marked:

Page 4

On a scale of 1-5, with 5 being the highest rating:

How important is your dental health to you? *

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Where would you rate your current dental health? *

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Where do you want your dental health to be? *

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

What would you like to change about your smile?

☐ Color ☐ Bite ☐ Chipped Teeth ☐ Spaces

☐ Crowding ☐ Smile Makeover ☐ Missing Teeth ☐ Whiter Teeth

What is the most important thing to you about your future smile and dental health?

Page 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient`s) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient's First Name *

Patient's Last Name *

Signature *

Today's Date

06/13/2023

Dental Insurance Form

Page 1

Policy Holders Primary Dental Insurance Information

We need your Dental Insurance information, NOT your medical insurance information (they are different)

Are you covered under a dental insurance plan? *

○ Yes ○ No

Is the patient the dental insurance policy holder? *

○ Yes ○ No

Please attach a picture of your dental insurance card

(if available)

Make sure the photo is in focus and not blurry.

Front of Dental Insurance Card

Drop files to attach, Use Camera, or browse

Back of Dental Insurance Card

Drop files to attach, Use Camera, or browse

Policy Holders First Name *

Policy Holders Last Name *

Policy Holders Birth Date *

__/__/____

Policy Holders SSN# *

___-__-____

Policy Holders Employer *

Dental Insurance Carrier *

Dental Insurance phone number *

(___) ___-____

(located on back of your dental insurance card)

ID / Member # *

Group # *

Plan *

Financial Policy Form

PAYMENT ARRANGEMENT FORM

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, credit cards and outside patient financing.

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges up to 35%.

Do You Have Insurance?

- We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.
- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the ***estimated*** amount, not covered by your insurance company, by cash, check, credit card or Patient Financing at the time we provide the service to you.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

In fairness to all our patients, we ask that you **notify our office at least 48 business hours in advance if you cannot keep your scheduled appointment**. For any appointments missed or cancelled/changed within 48 business hours of your scheduled appointment, we reserve the right to assess a minimum of $75.00 fee per occurrence. For excessive violations, we also reserve the right to require payment of full treatment fee (non-refundable) in advance to reserve an appointment OR discontinuation of our care for you.

Consent:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office.I understand that 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 financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

Responsible party's information

Who is the responsible party for payments? *

○ Patient ○ Someone else

Patients First Name *

Patients Last Name *

Responsible Party Signature *

Today's Date

06/13/2023

Medical History Form

Do you have any of the following Conditions?

Patient's First Name *

Patient's Last Name *

Do you have any of the following Conditions?

Anemia * ○ Yes ○ No

Anxiety * ○ Yes ○ No

Arthritis * ○ Yes ○ No

Artific. Heart Valve * ○ Yes ○ No

Asthma * ○ Yes ○ No

Blood Disease * ○ Yes ○ No

Bruise Easily * ○ Yes ○ No

Cancer * ○ Yes ○ No

Cerebral Palsy * ○ Yes ○ No

Depression * ○ Yes ○ No

Diabetes * ○ Yes ○ No

Emphysema * ○ Yes ○ No

Epilepsy * ○ Yes ○ No

Excessive Bleeding * ○ Yes ○ No

Fainting * ○ Yes ○ No

Glaucoma * ○ Yes ○ No

Heart Disease * ○ Yes ○ No

Jaundice * ○ Yes ○ No

Jaw Joint Pain * ○ Yes ○ No

Joint Replacement * ○ Yes ○ No

Kidney Disease * ○ Yes ○ No

Liver Disease * ○ Yes ○ No

Lung Disease * ○ Yes ○ No

Mental Disorders * ○ Yes ○ No

Mitral Valve Prolaps * ○ Yes ○ No

Pacemaker * ○ Yes ○ No

Radiation Treatment * ○ Yes ○ No

Respiratory Problems * ○ Yes ○ No

Rheumatic Fever * ○ Yes ○ No

Rheumatism * ○ Yes ○ No

Scarlet Fever * ○ Yes ○ No

Seizures * ○ Yes ○ No

Sinus Problems * ○ Yes ○ No

Stomach Problems * ○ Yes ○ No

Yes No

Heart Murmur *
Yes No

Heart Surgery *
Yes No

Hepatitis A *
Yes No

Hepatitis B *
Yes No

Hepatitis C *
Yes No

High Blood Pressure *
Yes No

HIV *
Yes No

Stroke *
Yes No

Thyroid *
Yes No

Tuberculosis *
Yes No

Tumors *
Yes No

Ulcers *
Yes No

Venereal Disease *
Yes No

Vertigo *
Yes No

Add unlisted conditions here (one item per entry)

Enter the item not listed here

Do you have any of the following Allergies?

Do you have any of the following Allergies?

Amoxicillin Allergy *
Yes No

Hydrocodone *
Yes No

Ibuprofen Allergy *
Yes No

Latex Allergy *
Yes No

NSAIDS *
Yes No

Opioids *
Yes No

Add unlisted allergies here (one item per entry)

Enter the item not listed here

☐ I have disclosed all my allergies. *

Additional Questions

Additional Questions

Please list any medications or prescriptions you're using

Date of last exam

MM/dd/yyyy

Have you had any serious illness, operation, or hospitalization in the past 5 years? *

Yes No

Are you on a special diet? *

Yes No

Have you had any head or neck injuries? *

Yes No

Do you experience any tooth sensitivity? *

Yes No

Do you grind your teeth? *

Yes No

Do you smoke or chew tobacco? *

Yes No

Are you pregnant?

Yes
No
Not Applicable

Are you breast feeding?

Yes
No
Not Applicable

Sign Here

Signature *

Date *

06/13/2023

Patient Information Form

Page 1

Patient Information

First Name *

Last Name *

Middle Initial

Date of Birth *

__/__/____

Age

Social Security Number

___-__-____

Today's date

06/13/2023

Gender *

- Male
- Female

Marital Status *

- Single
- Married
- Seperated
- Divorced
- Widowed
- Child
- Other

Are you the patient or are you filling out the forms for them? *

- I am the Patient
- I am filling out for the patient

Page 2

Patient Contact Information

Mobile Phone Number *

(___) ___-____

Email *

Home Phone Number

(___) ___-____

Drivers License

Address 1 *

Address 2

Optional

City *

State *

Please select

Zip Code *

_____

Page 3

Emergency Contact Information

Full Name

Phone Number

(___) ___-____

Relationship to Patient

Page 4

How did you hear about us?

Please select at least 1 option
*

- [ ] In-home Mailer
- [ ] Social Media
- [ ] Insurance
- [ ] Practice Website
- [ ] Internet
- [ ] Family / Friend / Co-worker
- [ ] Other

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To the best of my knowledge, all the information I have provided is true.

Patients First Name *

Patients Last Name *

Signature *

Today's Date

06/13/2023