## PATIENT INFORMATION

Date_____Patient Name_____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Date of Birth_____Social Security #_____Driver's License #_____

Address_____Apt#_____City & Zip_____

Home Phone_____Work Phone_____Cell Phone_____Pager_____

When was your last dental visit?_____Last dental xrays?_____Name of Last Dentist?_____

**How did you learn about our office? Phone Book_____ Name of Person_____Other_____**

## RESPONSIBLE PARTY or PRIMARY INSURANCE PROVIDER

Name_____

☐ Male ☐ Female Relationship to patient ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Other

Social Security #_____Date of Birth_____

Home Phone _____Work Phone_____CellPhone_____Pager_____

Address_____Apt#_____City & Zip_____

Employer Name_____ Occupation_____

## PRIMARY DENTAL INSURANCE INFORMATION NEEDED TO BILL CLAIMS

Insured's Employer Name providing insurance or check here if same as above ☐_____

Insurance Carrier Name_____

Mailing Address_____Phone #_____

Group or Plan Number#_____

## OTHER INSURANCE? - PLEASE PROVIDE INFORMATION NEEDED TO BILL CLAIMS

Name of Insured_____ Is insured a patient? ☐ Yes ☐ No

Insured's address if different from above_____

Insured's Birth Date_____Social Security # _____Group Plan #_____

Insured's Employer Name_____

Insurance Carrier Name_____

Mailing Address_____

Patient's relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other_____

# PATIENT MEDICAL HISTORY

Date_____Patient's Name_____Date Of Birth_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

1. Are you in good health?.....yes no
2. Have there been any changes in your general health within the past year.....yes no
3. Date of your last physical exam_____
4. Physician's name_____
   Address_____
   Phone Number_____
5. Are you now under the care of a physician?.....yes no
6. Have you ever been hospitalized for any surgical operation or serious illness?..yes no
   Please explain_____
   _____
7. Are you taking any medicine(s) including non prescription medicine?.....yes no
   If yes, what medicines are you taking?
   _____
8. Have you had any abnormal bleeding?.....yes no
9. Do you bruise easily?.....yes no
10. Have you ever required a blood transfusion?.....yes no
11. Have you had a recent weight loss?.....yes no
12. Have you ever taken fen-phen or redux...yes no
13. Do you use tobacco?.....yes no
14. Are you wearing contact lenses?.....yes no
15. Do you have any disease, condition, problem not listed above that you think I should know about?.....yes no
    Please explain_____
    _____
    _____

**WOMEN ONLY:**

Are you pregnant or think you may be?....yes no
Are you nursing?.....yes no
Are you taking birth control pills?.....yes no

## ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:

Local anesthetics like novocaine.....yes no
Penicillin or other antibiotics.....yes no
Barbiturates, sedatives or sleeping pills.....yes no
Aspirin.....yes no
Iodine.....yes no
Any metals.....yes no
Latex rubber.....yes no
Other (please list)_____

## DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:

Aids or HIV infection.....yes no
Allergies.....yes no
Arthritis or rheumatism.....yes no
Anemia.....yes no
Asthma or hay fever.....yes no
Back problems.....yes no
Bleeding disorders.....yes no
Cancer/Tumors.....yes no
Chest pain or angina.....yes no
Congenital heart problem.....yes no
Cough that produces blood.....yes no
Chemotherapy/Radiation.....yes no
Cortisone treatment.....yes no
Cold sores fever blisters.....yes no
Chemical dependency.....yes no
Diabetes.....yes no
Epilepsy or seizures.....yes no
Eating disorders.....yes no
Fainting or dizzy spells.....yes no
Glaucoma.....yes no
Heart defect or heart murmur.....yes no
Heart trouble, heart attack.....yes no
Heart surgery.....yes no
High/low blood pressure.....yes no
Hepatitis, jaundice or liver disease.....yes no
Hives or skin rash.....yes no
Hypoglycemia.....yes no
Joint replacement or implant.....yes no
Kidney trouble.....yes no
Lung or breathing problems.....yes no
Mitral valve prolapse.....yes no
Mental health care.....yes no
Nervousness.....yes no
Pacemaker.....yes no
Rheumatic heart disease or rheumatic fever.....yes no
Scarlet fever.....yes no
Shortness of breath.....yes no
Swelling of feet, ankles, hands.....yes no
Stroke.....yes no
Stomach ulcer.....yes no
Sexually transmitted disease.....yes no
Sinus Trouble.....yes no
Thyroid problems.....yes no
Tuberculosis.....yes no
Tonsillitis.....yes no

## PATIENT DENTALHISTORY

Date_____Patient's Name_____Date Of Birth_____

1. Reason for this visit_____
2. When was your last dental visit?_____What was done then?_____
3. How often did you visit the dentist then?_____
4. Previous Dentist (name and locations)_____
5. Have you had a complete series of dental films (18 x-rays) taken? When_____Where_____
6. How often do you brush your teeth?_____How often do you floss your teeth?_____

1. Do your gums bleed while brushing or flossing?.....yes no
2. Are your teeth sensitive to hot or cold liquids/foods?.....yes no
3. Are your teeth sensitive to sweet or sour liquids/foods?.....yes no
4. Do you feel pain to any of your teeth?.....yes no
5. Do you have any sores or lumps in or near your mouth?.....yes no
6. Have you had any head, neck or jaw injuries?.....yes no
7. Have you ever experienced any of the following problems in your jaw?
   - clicking yes no
   - pain (joint, ear, side of face) yes no
   - difficulty in opening or closing yes no
   - difficulty in chewing yes no
8. Do you clench or grind your teeth.....yes no
9. Do you bite your lips or cheeks frequently....yes no
10. Have you noticed any loosening of your teeth.....yes no
11. Does food tend to become caught between your teeth?.....yes no
12. Have you ever had periodontal treatment (gums)?.....yes no
13. Ever worn a bite plate or other appliance?..yes no
14. Have you ever had any difficult extractions in the past?.....yes no
15. Have you ever had any prolonged bleeding following extractions?.....yes no
16. Do you wear dentures or partials, if yes, date of placement_____
17. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?.....yes no
18. If you could change anything about your smile what would you change?_____

## CONSENT FOR SERVICES AND FINANCIAL POLICY

1. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.
2. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
3. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient)_____.
4. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
5. As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred for their care and financial responsibility on the part of each patient must be determined before treatment.
6. I understand that all responsibility for payment for dental services provided in the office for myself or my dependents is mine, due and payable at the time services are rendered, unless other arrangements have been made. A service charge of 1 ½% per month (18% per annum) on unpaid balances will be charged on all accounts exceeding 90 days.
7. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Furthermore, I hereby authorize payment directly to Jas Grewal, DDS of the group insurance benefits otherwise payable to me.
8. I understand it is my responsibility to advise your office of any changes in the information contained on this form. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form and my dental care.
9. I have read the above conditions of treatment and payment and agree to their content.

_____

Signature of guarantor of payments and/or patient, parent or guardian  Date  Relationship to patient