Patient Name: ____ Date: ________________________
Last, First MI (Preferred Name)
Gender: ________________ Family Status: _____

Social Security #: ____ Birth Date: ____

Phone (Home): ______________________ (Work): __________________ Ext: ______________ Pager/Cell: _______________________

E-mail Address_______________________We occasionally send out an e-newsletters with announcements or news about our practice. Please, check here if you do Not wish to receive these ☐

Address: ____
Street Apartment #

____
City State Zip Code

Employer Name:__________________________Position:____________How Long there?_________________

Please, list other members of your immediate family who are patients in our office______________________________

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other________________

Name of person or office referring you to our practice: ____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ____________________________

Social Security #: ____________________________ Birth Date: ____

Phone (Home): ______________ (Work): ______________ Ext:_____ Best time to call: ______________________________

Address: ____
Street Apartment #

____
City State Zip Code

Insurance Information

Primary

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ________________ ID #: ____________________ Group #:____

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_________________

Insurance Plan Name and Address: ____

____

Secondary

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ________________ ID #: ____________________ Group #:____

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_________________

Insurance Plan Name and Address: ____

Health Information

Have you ever had any of the following? Please check those that apply:

☐ AIDS	☐ Excessive Bleeding	☐ Liver Disease	☐ Stroke
☐ Allergies ___________	☐ Fainting	☐ Mental Disorders	☐ Tuberculosis
___________	☐ Glaucoma	☐ Nervous Disorders	☐ Tumors
☐ Anemia	☐ Growths	☐ Pacemaker	☐ Ulcers
☐ Arthritis	☐ Hay Fever	☐ Pregnancy	☐ Venereal Disease
☐ Artificial Joints	☐ Head Injuries	Due date:__________	☐ Codeine Allergy
☐ Asthma	☐ Heart Disease	☐ Radiation Treatment	☐ Penicillin Allergy
☐ Blood Disease	☐ Heart Murmur	☐ Respiratory Problems	OTHER:
☐ Cancer	☐ Hepatitis	☐ Rheumatic Fever	☐ _________________
☐ Diabetes	☐ High Blood Pressure	☐ Rheumatism	
☐ Dizziness	☐ Jaundice	☐ Sinus Problems	☐ _________________
☐ Epilepsy	☐ Kidney Disease	☐ Stomach Problems	

Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain:____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain:____

Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain:____

Date of last health care exam:____ What was this exam for?_________

Are you currently receiving medical care? ☐ Yes ☐ No
If yes, nature of care: ____
Please list all the names and phone numbers of the physicians who are currently providing you a care:____

Are you required to be Pre-Medicate before dental treatment? ☐ Yes ☐ No

Women: Are you pregnant? ☐ Yes ☐ No
If no, are you planning a pregnancy in the near future? ☐ Yes ☐ No
Are you a nursing mother? ☐ Yes ☐ No
Are you taking birth control pills? ☐ Yes ☐ No

Are you a smoker? ☐ Yes ☐ No
If so, how much do you smoke per day? _________________

Please list any medications you are currently taking

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Do you take Antacids? ☐ Yes ☐ No
If yes, how often? ______________________________

Are you taking any herbal supplements/medicines? ☐ Yes ☐ No
If yes, which ones?___________________

Sugar in your diet: ☐ None ☐ Slight ☐ Moderate ☐ High

DENTAL HYSTORY

Referred by_______________________________________
Previous Dentist_____________________________ How long ______________________
Most Recent Dental Exam______________________ Most Recent dental x-ray_________
Most recent dental treatment____
'How often do you have your teeth cleaned? 3 mo. _4 mo. 6 mo. 1 year or more

WHAT IS YOUR IMMEDIATE DENTAL CONCERN?
____
____
____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

Do you like the appearance of your teeth or smile Yes☐ No☐
If No, please explain___________________________________
Are you interested in whitening your teeth? Yes☐ No☐
If you could change your smile, what would you do? __________
____
Have you ever had unfavorable dental experiences Yes☐ No☐.
If Yes, please explain__________________________________
Problems with effectiveness or bad reactions to dental anesthetic
Yes☐ No☐.
If Yes, please explain__________________________________
Do your gums bleed while brushing or flossing? Yes☐ No☐
Are your teeth sensitive to hot or cold liquids/foods? Yes☐ No☐
Are your teeth sensitive to sweet or sour liquids/foods? Yes☐ No☐
Do you feel pain to any of your teeth? Yes☐ No☐
Do you have any sores or lumps in or near your mouth? Yes☐ No☐.
Have you had any head, neck or jaw injuries? . Yes☐ No☐

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☐
Do you have frequent headaches? Yes☐ No☐
Do you clench or grind your teeth? Yes☐ No☐
Do you bite your lips or cheeks frequently? Yes☐ No☐
Have you ever had any difficult extractions in the past? Yes☐ No☐
Have you ever had any prolonged bleeding following extractions?
Yes☐ No☐
Have you had any orthodontic treatment? Yes☐ No☐
Do you wear dentures or partials? Yes☐ No☐
If yes, do they present you a problems, please
explain____
Have you ever received oral hygiene instructions
regarding the care of your teeth and gums? Yes☐ No☐

Consent for Services

The undersigned hereby authorizes Doctor to take X-Rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a through diagnosis of patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependants 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 or attorney fee will be added to any overdue balance. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

I understand that if I have 2 broken appointments, the TCDC will not make any further appointments, unless they are fully prepaid in advance.

I, the undersigned, have insurance with___________________________ and assign directly to TCDC all benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic
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.

I have read the above conditions of treatment and payment and agree to their content.

____ _________ Date: _____________ Relationship to Patient: __________________________________
Signature of patient, parent or guardian

____ Date: _____________ Relationship to Patient: ________________________________
Signature of guarantor of payment/responsible party