DENTAL ARTS
Complete Family Dental Care

Welcome

Thank you for selecting our dental health team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us. We will be happy to help.

Patient Information *(Confidential)*

Date_____

Social Security _____

Name _____ Birth Date _____

Gender: ❑ Male ❑ Female Check appropriate box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

If student and over 19 years old, name of school: _____

Address _____

City _____ State _____ Zip _____

Home Phone ( ) _____ Work Phone ( ) _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency? _____

Responsible Party

Name of person responsible for this account _____

Relationship to Patient _____ Phone ( ) _____

Email: _____

For your convenience, we accept the following methods of payment. Please check the option you prefer. Payment is due in full for each appointment. ❑ Cash ❑ Personal Check ❑ VISA ❑ MasterCard ❑ American Express ❑ Discover ❑ CareCredit®

Insurance Information

Subscriber Name _____

Relationship to Patient _____ Birth Date _____ Plan Type: ❑ Family ❑ Individual

ID Number _____ Group # _____

Subscriber's Employer _____

Insurance Company _____

Insurance Company Address _____

Phone ( ) _____

The above is the insurance coverage verified for the above named patient. Dental Arts as a courtesy will file insurance claims to the insurance company. The insured or patient authorizes the insurance company to pay the provider directly. All deductibles, co-payments, and denied claims will be the total responsibility of the patient. Please feel free to contact any Dental Arts' representative with any questions.

Insured or Patient Signature _____ Date _____

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Patient Medical History

Primary Care Physician _____ *Office Phone* _____ *Date of Last Exam* _____

1. Are you under medical treatment now? ❑Yes ❑No
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? ❑Yes ❑No
3. Are you taking any medication(s) including non-prescription medicine? ❑Yes ❑No
If yes, what medication(s) are you taking? _____
_____
4. Have you ever taken Phen-Fen/Redux? ❑Yes ❑No
5. Do you use tobacco? ❑Yes ❑No
6. Do you use controlled substances? ❑Yes ❑No
7. Are you wearing contact lenses? ❑Yes ❑No

8. Do you have or have you had any of the following?

High blood pressure ❑Yes ❑No	Heart disease ❑Yes ❑No	Chest pains ❑Yes ❑No
Heart attack ❑Yes ❑No	Cardiac pacemaker ❑Yes ❑No	Easily winded ❑Yes ❑No
Rheumatic fever ❑Yes ❑No	Heart murmur ❑Yes ❑No	Stroke ❑Yes ❑No
Swollen ankles ❑Yes ❑No	Angina ❑Yes ❑No	Hay Fever/allergies ❑Yes ❑No
Fainting/seizures ❑Yes ❑No	Frequently tired ❑Yes ❑No	Tuberculosis ❑Yes ❑No
Asthma ❑Yes ❑No	Anemia ❑Yes ❑No	Radiation therapy ❑Yes ❑No
Low blood pressure ❑Yes ❑No	Emphysema ❑Yes ❑No	Glaucoma ❑Yes ❑No
Epilepsy/convulsions ❑Yes ❑No	Cancer ❑Yes ❑No	Recent weight loss ❑Yes ❑No
Leukemia ❑Yes ❑No	Arthritis ❑Yes ❑No	Liver disease ❑Yes ❑No
Diabetes ❑Yes ❑No	Joint replacement or implant ❑Yes ❑No	Heart trouble ❑Yes ❑No
Kidney diseases ❑Yes ❑No	Hepatitis/Jaundice ❑Yes ❑No	Respiratory problems ❑Yes ❑No
AIDS or HIV infection ❑Yes ❑No	Sexually transmitted diseases ❑Yes ❑No	Mitral Valve Prolapse ❑Yes ❑No
Thyroid problems ❑Yes ❑No	Stomach troubles/ulcers ❑Yes ❑No	Other _____

9. Are you allergic to or have you had any reactions to the following?

Local anesthetics (e.g. Novocain) ❑Yes ❑No	Iodine ❑Yes ❑No
Penicillin or other antibiotics ❑Yes ❑No	Aspirin ❑Yes ❑No
Sulfa drugs ❑Yes ❑No	Any metals (e.g. nickel, mercury, etc.) ❑Yes ❑No
Barbiturates ❑Yes ❑No	Latex rubber ❑Yes ❑No
Sedatives ❑Yes ❑No	Other (please list) _____

10. Women Only:
a.) Are you pregnant or think you might be pregnant? ❑Yes ❑No
b.) Are you nursing? ❑Yes ❑No
c.) Are you taking oral contraceptives? ❑Yes ❑No

Patient Dental History

Previous Dentist and Location _____ *Date of Last Exam* _____

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?
a.) Clicking? ❑Yes ❑No
b.) Pain (joint, ear, side of face)? ❑Yes ❑No
c.) Difficulty in opening or closing? ❑Yes ❑No
d.) Difficulty in chewing? ❑Yes ❑No
8. Do you have frequent headaches? ❑Yes ❑No
9. Do you clench or grind your teeth? ❑Yes ❑No
10. Do you bite your lips or cheeks frequently? ❑Yes ❑No
11. Have you ever had any difficult extractions in the past? ❑Yes ❑No
12. Have you ever had any prolonged bleeding following extractions? ❑Yes ❑No
13. Have you had any orthodontic treatment? ❑Yes ❑No
14. Do you wear dentures or partials? ❑Yes ❑No
If yes, date of placement _____
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ❑Yes ❑No
16. Do you like your smile? ❑Yes ❑No

Authorization and Release

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 payers 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 dependents.

I have read and agree with Dental Arts' HIPAA (Notice of Privacy Practices) statement.

Signature of Patient (or Parent if Minor) _____ Date _____

Doctor's Comments _____

_____

_____ Signature _____ Date _____