

PATIENT INFORMATION

Date: _____ Social Security #: _____
 Patient Name: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Email: _____ Sex: M F Age: _____ Birthdate: _____
 Married Widowed Single Minor Separated Divorced Partnered for _____ years
 Occupation: _____ Patient Employer/School: _____
 Employer/School Address: _____
 Employer/School Phone: _____
 Spouse or Parent's Name: _____
 Birthdate: _____ Whom may we thank for referring you? _____
 Spouse or Parent's Employer: _____

INSURANCE

Primary

Dental Insurance: Yes No Subscriber's Name: _____
 Subscriber's Birthdate: _____ Subscriber's Employer: _____
 Insurance Company: _____ Group #: _____ Contract #: _____

Secondary

Dental Insurance: Yes No Subscriber's Name: _____
 Subscriber's Birthdate: _____ Subscriber's Employer: _____
 Insurance Company: _____ Group #: _____ Contract #: _____

PHONE NUMBERS

Home: _____ Work: _____ Ext.: _____ Cell: _____
 Spouse or Parent's Work: _____ Preferred Method of Contact: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____
 Home Phone: _____ Work Phone: _____

DENTAL HISTORY

Reason for today's visit: _____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist: _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State: _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit: _____	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays: _____	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you happy with the appearance of your smile? <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____
Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No	

HEALTH HISTORY

Physician's Name: _____ Date of last visit: _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- | | | | | | |
|--|--|-----------------------|--|---------------------------------|--|
| Abnormal Bleeding, with extractions or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | | Special Diet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Type _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or Growth on head or neck | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent or bloody | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Nervous Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Women:

Are you pregnant? Yes No Due date: _____ Are you nursing? Yes No Are you taking birth control pills? Yes No

MEDICATIONS

List any medications you are currently taking and the correlating diagnoses:

Pharmacy Name: _____

Phone: _____

ALLERGIES

- | | |
|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Barbiturates (sleeping pills) | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Other _____ | |

PAYMENT OF FEES

Payment at the time of services is expected. For your convenience, we accept Visa, American Express, MasterCard and Discover. Our office will be happy to submit claims to your insurance company. A service charge of 1½% per month will be added to all balances 60 days and older. The annual rate of the service charge is 18%.

I understand that Midlothian Dental Center will make every effort to collect from my insurance company. I hereby authorize Midlothian Dental Center to furnish information to insurance carriers concerning my treatment and I hereby assign to the dentist all payments for dental services rendered to me or my dependents. By signing this form, I acknowledge and understand that I am responsible for any amounts not covered by insurance for services rendered to me or my dependents. I also acknowledge and understand that if the account turned over to an attorney or agency for collection, I hereby agree to pay all attorney or collection agency fees on the unpaid balance.

Signature: _____ Date: _____

You will be asked to sign this document upon arrival for your appointment.

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