Welcome

1 ABOUT YOU

Today's Date: ___/___/___.

Patient Name: _____.
LAST FIRST MI

Preferred Name: _____ ☐ Male ☐ Female

Birth Date: ___/___/___ Age: ____ SS#: _____.

Mailing Address: _____.

_____.
CITY STATE ZIP

Home Phone #: (___)_____.
Work Phone #: (___)_____ Ext. _____.
Cell Phone #: (___)_____.
E-mail Address: _____.
Referred By: _____.
Employer: _____.
Employer's Address: _____.

_____.
CITY STATE ZIP

Occupation: _____.

Status: ☐ Child ☐ Single ☐ Married ☐ Divorced
Spouse's Name: _____.

2 INSURANCE

Primary Dental Insurance

Co. Name: _____.

Address: _____.

_____.
CITY STATE ZIP

Phone #: (____)_____.
Insured's SS #: _____.
Group #: _____.
Insured's Name: _____.
Relation: _____ Date of Birth: ___/___/___.
Insured's Employer: _____.

Secondary Dental Insurance

Co. Name: _____.

Address: _____.

_____.
CITY STATE ZIP

Phone #: (____)_____.
Insured's SS #: _____.
Group #: _____.
Insured's Name: _____.
Relation: _____ Date of Birth: ___/___/___.
Insured's Employer: _____.

3 ACCOUNT INFO

Person ultimately responsible for account

Name: _____.

Birth Date: ___/___/___ SS#: _____.

Relation: _____.

Billing Address: _____.

_____.
CITY STATE ZIP

Work Phone# : (____)_____.

Cell Phone #: (____)_____.

Payment Method: ☐ Cash ☐ Check ☐ Credit Card

_____ I hereby authorize assignment of my insurance benefits directly to the provider for services rendered. **I fully understand I am solely responsible for any balance not paid by my insurance company.**

Please Continue on Back

4 DENTAL INFO

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation

Are you in pain? ☐ Yes ☐ No How Long? _____.

Please indicate ☑ any of the following problems:

☐ Discomfort, clicking or popping in jaw. ☐ Lost/Broken Filling ☐ Stained teeth
☐ Red, swollen or bleeding gums. ☐ Teeth grinding ☐ Locking Jaw
☐ Sensitive tooth, teeth or gums. ☐ Ringing in Ears ☐ Bad Breath
☐ Blisters/Sores in or around mouth. ☐ Broken/Chipped tooth
☐ Other _____.

Do you require pre-medication? ☐ Yes ☐ No ☐ Don't Know

Previous Dentist: _____ (___) _____.

Last Dental Exam: ____/____/____ Last Dental X-rays: ____/____/____.

Times a day you brush? _____ Times a week you floss? _____.

What type of tooth brush bristles do you use? ☐ Soft ☐ Medium ☐ Hard

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (Best)

5 MEDICAL HISTORY

Are you taking any of the following medications? ☐ Nerve Pills ☐ Pain killers (including aspirin)

☐ Muscle relaxers ☐ Stimulants ☐ Blood Thinners ☐ Tranquilizers ☐ Insulin

☐ Other(s), please list: _____.

Do you have or have you had any of the following diseases, medical conditions or procedures?

Please indicate by **circling** the condition or disease.

Y N Heart Attack/Stroke	Y N Thyroid Problems	Y N Cancer/Tumors	Y N Cosmetic Surgery
Y N Heart Surg./Pacemaker	Y N Kidney Problems	Y N Shingles	Y N X-ray or Cobalt Treatment
Y N Heart Murmur	Y N Liver Problems	Y N Hepatitis A/B/C	Y N Chemotherapy
Y N Rheumatic Fever	Y N Respiratory Problems	Y N HIV/AIDS/ARC	Y N Asthma
Y N Mitral Valve Problems	Y N Sinus Problems	Y N Arthritis/ Rheumatism	Y N Difficulty Breathing
Y N Artificial Valves	Y N Stomach Problems	Y N Artificial Bones/Joints	Y N Diabetes/ Hypoglycemia
Y N Heart Disease	Y N Psychiatric Problems	Y N Emphysema	Y N Leukemia
Y N Congenital Heart Defect	Y N Venereal Disease	Y N Fainting/Seizures/Epilepsy	Y N Anemia
Y N Chest Pains	Y N Alcohol/Drug Abuse	Y N Severe/Frequent Headaches	Y N High/Low Blood Pressure
Y N Scarlet Fever	Y N Tuberculosis	Y N Frequent Neck Pain	Y N Bleeding Problems
Y N Nervousness	Y N Jaw Problems TMJ/TMD	Y N Back Problems	Y N Glaucoma
Y N Phen- Phen	**Y N** Acid Reflux		

Please list any other surgeries or medical conditions you have or ever had: _____.

Are you allergic to any of the following? ☐ Latex ☐ Penicillin / ☐ Amoxicillin ☐ Tetracycline ☐ Aspirin

☐ Dental Anesthetics ☐ Others _____.

Do you use tobacco? ☐ No ☐ Yes / How is it Used? _____ How often? _____ How Long? _____.

Women only: Are you Pregnant? ☐ No ☐ Yes / How long? _____ Are you nursing? ☐ No ☐ Yes

Consent For Services

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the Doctor at the next appointment without fail. Due to the importance of time necessary to provide excellent dental care, office policy is to the effect that three unexcused broken appointments may result in dismissal from the practice. **We respectfully request a minimum of 24 hours notice if you are unable to make your appointment.** Also, failure to show for an appointment will result in a "NO SHOW" fee being assessed to your account. We are a "Fee for Service" practice. A service charge of 1 ½% per month (18% annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. If it becomes necessary to refer the account to a collection agency, I agree to pay a collection fee of 40% of the principal balance owing. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit were instituted hereunder. I grant my permission to the Doctor, or his assignee, to telephone me at home or at work to discuss matters related to this form, I have read the conditions of treatment and payment and agree to their content. I do consent to services provided by Family First Dentistry.

_____ Date: _____ Relationship to Patient: _____.

Signature of patient, parent or guardian