Welcome

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

PATIENT INFORMATION

Name: ______________________ Birthdate ____________ S.S.# ____________

Address ______________________ City ____________ State ____ Zip ________

Sex ☐ M ☐ F Home Phone ____________ Cell Phone ____________ E-mail ____________

Employer ______________________ Employer Phone ______________________

Spouse or Parent's Name ____________ Employer ____________ Work Phone ____________

How did you hear about our office? ______________________

Person to contact in case of emergency ______________________ Phone ____________

RESPONSIBLE PARTY (if different from patient)

Name of Person
Responsible for this Account ______________________ Relation to Patient ____________

Currently a patient in our office? ☐ Yes ☐ No

Home Phone ______________________

Work Phone ______________________

Cell Phone ______________________

Email ______________________

INSURANCE INFORMATION

Name of Insured ______________________ Relation to Patient ____________

Birthdate ____________ S.S.# ____________

Employer ______________________ Work Phone ____________

Employer City ______________________ ST ________ Zip ________

Insurance Company ______________________ Group # ____________ Subscriber ID# ____________

ADDITIONAL INSURANCE

Name of Insured ______________________ Relation to Patient ____________

Birthdate ____________ S.S.# ____________

Employer ______________________ Work Phone ____________

Employer City ______________________ ST ________ Zip ________

Insurance Company ______________________ Group # ____________ Subscriber ID# ____________

DENTAL HISTORY

Reason for today's visit ______________________ Date of last dental care ____________

Previous Dentist ______________________ Date of last dental X-rays ____________

Check (✓) if you have had problems with any of the following:

☐ Bad breath
☐ Bleeding gums
☐ Clicking or popping jaw
☐ Food collection between teeth
☐ Loose teeth or broken fillings
☐ Grinding teeth
☐ Sensitivity to hot
☐ Sensitivity to sweets
☐ Periodontal treatment
☐ Sensitivity to cold
☐ Sores or growths in your mouth
☐ Sensitivity when biting

How often do you floss? ____________ How often do you brush? ____________

OVER - CONTINUED ON BACK

MEDICAL HISTORY

Are you under a physician's care now? ☐ Yes ☐ No

Have you ever had a serious head or neck injury? ☐ Yes ☐ No

Did you ever take the drug Phen-Fen or Redux? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No

Have you been hospitalized or had a major operation? ☐ Yes ☐ No

Please list any medications you are taking.

_______________ _______________

_______________ _______________

_______________ _______________

_______________ _______________

Have you ever taken Fosamax, Boniva, Actonel or any other medications for osteoporosis? ☐ Yes ☐ No

Are you allergic to:

Aspirin	☐ Yes ☐ No
Penicillin	☐ Yes ☐ No
Codeine	☐ Yes ☐ No
Acrylic	☐ Yes ☐ No
Metal	☐ Yes ☐ No
Latex	☐ Yes ☐ No
Local Anesthetic	☐ Yes ☐ No

Women are you:

Pregnant/trying to get pregnant?	☐ Yes ☐ No
Taking oral contraceptives?	☐ Yes ☐ No
Nursing?	☐ Yes ☐ No

Please list any other allergies: _______________

____

____

____

Check (✓) if you have had or have any of the following:

☐ Aids/HIV Positive	☐ Chest Pains	☐ Frequent Diarrhea	☐ Irregular Heartbeat	☐ Fever Shingles
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Frequent Headaches	☐ Kidney Problems	☐ Sickle Cell Disease
☐ Anemia	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sinus Trouble
☐ Anaphylaxis	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Spina Bifida
☐ Angina	☐ Cortisone Medication	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Stomach Disease
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stroke
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Swelling of Limbs
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Thyroid Disease
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Tonsillitis
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tuberculosis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis Tumors or Growth Ulcers
☐ Breathing Problems	☐ Anemia	☐ Herpes	☐ Recent Weight Loss	
☐ Bruise Easily	☐ Excessive Thirst	☐ High Blood Pressure	☐ Renal Dialysis	☐ Venereal Disease
☐ Cancer	☐ Fainting Spells/Dizziness	☐ Hives or Rash	☐ Rheumatic Fever	☐ Yellow Jaundice
☐ Chemotherapy	☐ Frequent Cough	☐ Hypoglycemia	☐ Rheumatism Scarlet	

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with (Name of Insurance Company(ies) _______________ and assign directly to Sullivan Dental Partners all insurance 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 authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

Signature of Patient or Responsible Party _______________ Date _______________

Print name of Patient or Responsible Party _______________ Relationship to Patient _______________

Payment is due in full at time of treatment unless prior arrangements have been approved.