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Raleigh, NC 27605

PATIENT'S NAME _____
PREFERRED NAME _____ DATE: _____
SOCIAL SECURITY # _____

1 ABOUT YOU

Sex: Male Female
Birthdate: _____/_____/_____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone Number: (____)_____-_____
Work Phone Number: (____)_____-_____ Ext. ____
Cell Phone Number: (____)_____-_____
Email Address: _____
Status: Minor Single Married Divorced Separated Widowed
Spouse's Name: _____
Do you have children? Yes No
How many? _____
Referred By: _____
Employer: _____ How long?: _____
Employer Address: _____
City: _____ State: _____ Zip: _____
Occupation: _____

2 INSURANCE INFORMATION

Primary Dental Insurance
Company Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Phone Number: (____)_____-_____
Insured's ID Number: _____
Group Number: _____
Insured's Name: _____
Relation: _____
Birthdate: _____/_____/_____
Insured's Employer: _____

Secondary Dental Insurance
Company Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Phone Number: (____)_____-_____
Insured's ID Number: _____
Group Number: _____
Insured's Name: _____
Relation: _____
Birthdate: _____/_____/_____
Insured's Employer: _____

3 ACCOUNT INFORMATION

Person ultimately responsible for account
Name: _____
Relation: _____
Billing Address: _____
City: _____ State: _____ Zip: _____
Drivers License Number: _____
Work Phone Number: (____)_____-_____ Ext. ____
Payment Method: Cash Check
_____/_____
 Credit Card (Number) (Date)

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not apid by my insurance company (if offered at this office).

Signature: _____

4 IN THE EVENT OF AN EMERGENCY

Whom should we contact: _____
Relation: _____
Home Phone Number: (____)_____-_____
Work Phone Number: (____)_____-_____ Ext. ____
Cell Phone Number: (____)_____-_____
Who is your Medical Doctor? _____
Medical Doctor's Phone: (____)_____-_____

5 MEDICAL HISTORY

What medications are you taking?
 Nerve pills Blood Thinners
 Pain killers Tranquilizers
(including aspirin) Insulin
 Muscle Relaxers Meds for Osteoporosis
 Stimulants
Other(s), please list: _____

Have you ever taken:
 Bisphosphonates (ex. Aredia/Fosamax)
 Phen-fen/Redux

6 DENTAL HISTORY

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

- | | |
|---|---|
| <input type="checkbox"/> <input type="checkbox"/> Heart Attack/Stroke | <input type="checkbox"/> <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> <input type="checkbox"/> Heart Surgery/ | <input type="checkbox"/> <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> <input type="checkbox"/> Pacemaker | <input type="checkbox"/> <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> <input type="checkbox"/> Stomach Problems/
Ulcers |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Valves | <input type="checkbox"/> <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> <input type="checkbox"/> Heart Disease | <input type="checkbox"/> <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> <input type="checkbox"/> Alcohol/Drug Abuse |
| <input type="checkbox"/> <input type="checkbox"/> Chest Pains | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis TB |
| <input type="checkbox"/> <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> <input type="checkbox"/> Jaw Problems TMJ/TMD |
| <input type="checkbox"/> <input type="checkbox"/> Nervousness | <input type="checkbox"/> <input type="checkbox"/> Cosmetic Surgery |
| <input type="checkbox"/> <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> <input type="checkbox"/> Xray or Cobalt Treatment |
| <input type="checkbox"/> <input type="checkbox"/> Shingles | <input type="checkbox"/> <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> <input type="checkbox"/> Hepatitis | <input type="checkbox"/> <input type="checkbox"/> Asthma |
| <input type="checkbox"/> <input type="checkbox"/> HIV+/AIDS/ARC | <input type="checkbox"/> <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> <input type="checkbox"/> Diabetes/Hypoglycemia |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Bones/Joints | <input type="checkbox"/> <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> <input type="checkbox"/> Emphysema | <input type="checkbox"/> <input type="checkbox"/> Anemia |
| <input type="checkbox"/> <input type="checkbox"/> Fainting/Seizures/ | <input type="checkbox"/> <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> <input type="checkbox"/> Epilepsy | <input type="checkbox"/> <input type="checkbox"/> Bleeding Problems |
| <input type="checkbox"/> <input type="checkbox"/> Severe/Frequent | <input type="checkbox"/> <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> <input type="checkbox"/> Headaches | |
| <input type="checkbox"/> <input type="checkbox"/> Frequent Neck Pain | |
| <input type="checkbox"/> <input type="checkbox"/> Back Problems | |

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

Are you allergic to any of the following?

- | | |
|---|---|
| <input type="checkbox"/> Latex | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Penicillin/Amoxicillin | <input type="checkbox"/> Dental Anesthetics |
| <input type="checkbox"/> Tetracycline | |

Foods: _____

Others: _____

Do you use tobacco?

- No Yes / How used?: _____
How much?: _____
How long?: _____

Please rate your general health from 1-10: _____

Do you wear contact lenses? Yes No

Are you taking birth control pills?
 Yes No

Are you pregnant? Yes No

If so, for how long? _____

Are you nursing? Yes No

Reason for today's visit:

- Exam Emergency Consultation

Are you in pain?

- No Yes/How long? _____

Please indicate any of the following problems:

- | | |
|---|---|
| <input type="checkbox"/> Discomfort, clicking or popping of jaw | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Red, swollen or bleeding gums | <input type="checkbox"/> Broken/chipped tooth |
| <input type="checkbox"/> Sensitive tooth, teeth or gums | <input type="checkbox"/> Stained teeth |
| <input type="checkbox"/> Blisters/sores in or around the mouth | <input type="checkbox"/> Locking jaw |
| <input type="checkbox"/> Lost/broken filling(s) | <input type="checkbox"/> Bad breath |
| <input type="checkbox"/> Teeth grinding | |

Other(s), please list: _____

Last dental exam: _____/_____/_____

Last dental x-rays: _____/_____/_____

Times a day you brush: _____

Times a day you floss: _____

What type of tooth brush bristles do you use?

- Soft Medium Hard

How would you rate your smile?

- 1 2 3 4 5 6 7 8 9 10
(worst) (best)

7 PATIENT AUTHORIZATION

We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

SIGNATURE: _____

DATE: _____/_____/_____

UPDATE (office use only)

Initials: _____ Initials: _____ Initials: _____

Date: _____ Date: _____ Date: _____