DENTAL HEALTH HISTORY

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

Are you in pain? ❑ No ❑ Yes How long?________________

Please indicate any of the following problems:

❑ Discomfort, clicking or popping in jaw. ❑ Blisters/Sores in or around the mouth. ❑ Ringing in Ears ❑ Locking Jaw

❑ Red, swollen or bleeding gums. ❑ Lost/Broken Filling(s) ❑ Broken/Chipped tooth ❑ Bad breath

❑ Sensitive tooth, teeth or gums ❑ Teeth grinding ❑ Stained teeth

❑ Other: ____

Do you require pre-medication ❑ Yes ❑ No ❑ Don't know

Previous Dentist: ________________________________ (____)______________

Name Phone#

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

Do you have any disease, condition, or problem not listed previously that you feel we should know about? ❑ No ❑ Yes

If so, please describe: ____

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Person Financially Responsible For Patient Must Fill Out Below Areas Completely.

Name ____

Home Phone # ______________________ Work Phone #______________________Cell Phone #______________________

Message # ______________________E-mail address:______________________

Billing or Home Address: ______________________ City______________________ Zip ____________

Mailing Address (if different):______________________ City______________________ Zip ____________

Employer______________________ Job Title ______________________

Primary insured person's birthdate ____________Social Security # ______________ Primary Ins. Co. ______________

Ins. Address ____

Group/Policy # ______________________ Yearly Maximum ______________________

Yearly Deductible ______________________ Calendar Year ______________________

Secondary Name ______________________ Work phone # ______________________

Secondary Employer ______________________ Job Title ______________________

Secondary insured person's birthdate __________Secondary Social Security # ____________Secondary Ins. Co. ____________

Secondary Ins. Co. Address ______________________ Group/Policy # ______________________

Yearly Maximum ______________________Yearly Deductible ______________________Calendar Year ______________________

If information is for a minor child their Social Security #______________________

Whom may we thank for referring you to our office? ______________________________

In the event of an emergency whom should we contact and phone # ______________________________

- Hippa privacy policies are available to view in our reception/front desk area
- 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.
- We invite you to discuss with us any questions regarding our service. The best Dental health services are based on a friendly, mutal understanding between provider and patient
- 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 ______________________

❑ Adult Patient ❑ Parent or Guardian ❑ Spouse