PATIENT INFORMATION

Name:______________________________________ Date of Birth: ________________________

Address:____________________________________ Social Security #: ______________________

City/State/Zip: ______________________________ Drivers License #: ______________________

Phone:
Home: ____________________ Work: ______________________ Mobile: _______________________
E-mail: ____
*Please indicate your preference for contact: email or phone (circle one).

Family status: _______Married _______Single _______ Child
Identified gender: _______M _______ F _______X

Employer's Name: _______________________________________

In case of an emergency, who should be notified? Please enter name, phone number and relationship:

____

MEDICAL HISTORY

Have you had any of the following conditions? Please check those that apply:

	Heart Problems		Jaundice		Tuberculosis
	High Blood pressure		Malignancies		Fainting / Epilepsy
	Heart Murmur		Radiation Therapy		HIV/ AIDS
	Mitral Valve Prolapse		Chemotherapy		Blood Transfusion
	Artificial Valves		Thyroid Problems		Artificial Joints
	Rheumatic Fever		Respiratory Problems		Drug Allergies
	Diabetes		Asthma		Latex Allergies
	Hepatitis		Sinus Problems		Are you currently pregnant

Are you allergic to any medication? ____

Are you currently under the care of a physician? ____

If yes, please explain: ____

Are you currently taking any medication: ____

If yes, please list them: ____

Do you have any health condition that need further clarification? __________________________

If yes, please explain: ____

DENTAL HISTORY

Date of last dental visit?___________________Reason for today's visit:____________________________

Check all that apply:

_____ Complication with past dental visits

_____ Trouble getting numb

_____ Bad reaction to local anesthetic

_____ Experiencing dry mouth

_____ Any teeth sensitivity to hot, cold, sweets, or biting down

_____ Food being trapped in between teeth

_____ Experiencing popping or clicking of TMJ(jaw)

_____ Clenching or grinding teeth

_____ Bleeding gums when brushing and flossing

_____ History of gum disease

_____ History of smoking or chewing tobacco

_____ Anything about the appearance of your smile that you would like to improve

REFERRAL INFORMATION

How did you hear about our practice?

_________ Another Patient __________ Another Doctor __________ Google ___________ Yelp

Who may we thank for referring you to our practice? ___________________________________

POLICY HOLDER INFORMATION

Name: ________________________________ Relation: ______________________________

Date of Birth: _________________________ SS#: __________________________________

Address: ______________________________ Phone (Home): _________________________

City/State/Zip: _________________________ Phone (Mobile): ________________________

Employer: _____________________________ Dental Insurance: _______________________

Group #: ______________________________ Subscriber #: __________________________

Insurance______________________________ Phone Number__________________________

CONSENT FOR SERVICES

- 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. Patient is solely responsible for any balance not paid by their insurance company. 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 remaining balance, 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 Downtown Dental Design to release any information 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: ____