**FIRST CHOICE DENTAL CENTER**

*Thank you for selecting our dental office! We are committed to providing you the best possible dental care. To help us meet your entire dental healthcare needs, please fill out this form completely and in ink. If you have any questions, please, feel free to ask.*

## *Patient Information* *Confidential*

Patient's Name ☐ Mr. ☐ Mrs. ☐ Ms. Today's Date ____________________

______________________________________________ Birthdate ____________________

Last First MI

Whom may we thank for referring you? ______________________________________________

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Patient Social Sec. Number: ______ - ______ - ______ Patient's Phone ( ) -

If this is a cell may we text you appointment reminder? ☐ YES ☐ NO

Patient's Address: ______________________________________________

Street City State ZIP

Email: ______________________________ May we send you appointment reminders via email? ☐Yes ☐No

Patient's Employer: ______________________________ Work Phone: ( ) -

Person to Contact in case of emergency: ______________________________ Phone: ( ) -

## *Responsible Party Information* (write "Same" if same as patient above)

Name of person responsible for this account? ______________________________ Relationship to Patient ____________

Address: ______________________________________________

Street City State ZIP

Birthdate: ____________ Soc. Sec. Number ____ - ____ - ____ Home Phone Number ( ) -

Employer: ______________________________ Work Phone Number ( ) -

Employer's Address: ______________________________________________

Street City State ZIP

Is this person currently a patient at our office? ☐ YES ☐ NO

## *Insurance Information* (only if different from patient or Responsible Party listed above)

Name of Insured: ______________________________ Relationship to Patient ____________

Birthdate: ____________ Soc. Sec. Number: ____ - ____ - ____ Home Phone ( ) -

Employer: ______________________________ Work Phone ( ) -

Employer's Address: ______________________________________________

Street City State ZIP

**Do you have any additional insurance? ☐ YES ☐ NO** **If YES, please ask for an additional form**

## *Patient Medical History*

**Are you allergic to, or have you had any reaction to the following:**

| | YES | NO |
|---|---|---|
| Local Anesthetics? | ☐ | ☐ |
| Penicillin or antibiotics? | ☐ | ☐ |
| Sulfa Drugs? | ☐ | ☐ |
| Barbiturates? | ☐ | ☐ |
| Sedatives | ☐ | ☐ |
| Iodine? | ☐ | ☐ |
| Aspirin? | ☐ | ☐ |
| Latex rubber? | ☐ | ☐ |
| Any metals (e.g. nickel, mercury)? | ☐ | ☐ |
| Codeine? | ☐ | ☐ |
| Other? (Please list)____________ | ☐ | ☐ |

Physician's name: ____________________ Phone: ______________

Date of last exam: ____________________

| | YES | NO |
|---|---|---|
| Are you under medical treatment now? | ☐ | ☐ |
| Have you been hospitalized for any serious illness within the last 5 years? Please explain: ____________ | ☐ | ☐ |
| Are you pregnant, or think you may be? | ☐ | ☐ |
| Are you taking any medication(s), including Non-prescription medicine? | ☐ | ☐ |
| Do you use tobacco products? | ☐ | ☐ |
| Do you use controlled substances? | ☐ | ☐ |
| Are you wearing contact lenses? | ☐ | ☐ |
| Have you ever taken Phen Fen? | ☐ | ☐ |

**Over Please**

## *Patient Medical History (continued)*

Do you have now, or have you ever had, any of the following?

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| High blood pressure ………………………. | ☐ | ☐ | Heart disease ………………… | ☐ | ☐ | Chest pain ………… | ☐ | ☐ |
| Heart attack ………………………………. | ☐ | ☐ | Cardiac pacemaker ………..… | ☐ | ☐ | Easily winded ……… | ☐ | ☐ |
| Rheumatic Fever …………………………. | ☐ | ☐ | Heart murmur ……………..… | ☐ | ☐ | Stroke ……………... | ☐ | ☐ |
| Rheumatic Heart Disease ………………… | ☐ | ☐ | Angina ……………………… | ☐ | ☐ | Hay Fever/allergies… | ☐ | ☐ |
| Swollen ankles ……………………………. | ☐ | ☐ | Frequently tired …………….. | ☐ | ☐ | Tuberculosis ………. | ☐ | ☐ |
| Fainting/seizures ………………………….. | ☐ | ☐ | Anemia …………………….. | ☐ | ☐ | Radiation therapy …. | ☐ | ☐ |
| Asthma ……………………………………. | ☐ | ☐ | Emphysema ……………..… | ☐ | ☐ | Glaucoma …………. | ☐ | ☐ |
| Low blood pressure ……………………….. | ☐ | ☐ | Cancer ……………….……… | ☐ | ☐ | Recent weight loss … | ☐ | ☐ |
| Epilepsy/convulsions ……………………… | ☐ | ☐ | Arthritis …………………..…. | ☐ | ☐ | Liver disease ………. | ☐ | ☐ |
| Leukemia ………………………………….. | ☐ | ☐ | Joint replacement/implant ….. | ☐ | ☐ | Heart trouble ………. | ☐ | ☐ |
| Diabetes ……………………………………. | ☐ | ☐ | Hepatitis / Jaundice ………… | ☐ | ☐ | Respiratory problems. | ☐ | ☐ |
| Kidney disease ……………………………. | ☐ | ☐ | Venereal Disease …………… | ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ |
| Thyroid problem ………………………….. | ☐ | ☐ | Stomach problem / ulcer …… | ☐ | ☐ | Bleed easily ……….. | ☐ | ☐ |
| Blood transfusion …………………………. | ☐ | ☐ | Rheumatoid Arthritis ………. | ☐ | ☐ | Other ____________ | ☐ | ☐ |

## *Patient Dental History*

Name of previous dentist and location: ________________________________________________ Date of last Exam ____________

| | YES | NO |
|---|---|---|
| Do you gums bleed while brushing? ……………….. | ☐ | ☐ |
| Are your teeth sensitive to hot or cold? …………..… | ☐ | ☐ |
| Are your teeth sensitive to sweet or sour? …………. | ☐ | ☐ |
| Do you have any sores/ lumps in/near your mouth? .. | ☐ | ☐ |
| Have you had any head, neck, or jaw injuries? …….. | ☐ | ☐ |

**Have you ever experienced any of the following in your jaw?** ☐ Difficulty opening or closing ☐ Clicking ☐ Pain (joint, ear, side of face) ☐ Difficulty chewing

| | YES | NO |
|---|---|---|
| Do you have frequent headaches?…………………… | ☐ | ☐ |
| Do you clench or grind your teeth? …………………. | ☐ | ☐ |
| Do you bite your lips or cheek frequently? …………. | ☐ | ☐ |
| Have you had difficult extractions before? …………. | ☐ | ☐ |
| Have you had prolonged bleeding after extractions? .. | ☐ | ☐ |
| Have you had any orthodontic treatment? ………….. | ☐ | ☐ |
| Do you wear dentures/partials? ……………………... | ☐ | ☐ |
| Date of placement ___________________ | | |
| Have you ever had instruction on the care of your teeth? … | ☐ | ☐ |
| **Do you like your smile?…………………………….…..** | ☐ | ☐ |

What would you change about it? ____________________________

____________________________________________________

## *Payment Information*

I agree to pay for all professional fees and treatment at the time of service, or my portion not covered by dental insurance, for other, or myself above named persons I am responsible for, unless other financial arrangements are approved. I also agree to pay for all costs of collection, including attorney fees and court costs, should additional means of collection be required. In addition, my signature on this form is my acknowledged authorization for First Choice Dental Center to seek a credit report, if credit is extended. I also acknowledge the fact that there is a charge for any missed appointment, unless cancelled **24 hours** in advance, or cancelled before 9:00 AM Friday for Monday appointments.

## *Authorization for Release*

I certify that I have read and understand the above information. I have answered all questions accurately and I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information, including the diagnosis, x-rays and the records of any treatment or examination rendered on me, or my children, to third party payers and/or health practitioners. I understand that dental insurance companies will occasionally audit records in a dental office. I understand that this release **does not** authorize any one-time audit of my health records. I must sign a specific release to my insurance company for any record audit at the time of that audit. I understand that any photos taken in the dental office are property of First Choice Dental Center. I understand that the doctor may show patients requiring similar treatment photos of my teeth (no full-face pictures) as visual aids.

I authorize and request my insurance company to pay directly to the dentist, or dental group, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

***X***______________________________________________ ______________________________________________

*Signature of patient (or parent, if a minor)* *Date* *Signature of doctor* *Date*