

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 _____

Last First MI

Birthdate _____

Whom may we thank for referring you? _____

Check appropriate box: Minor Single Married Widowed Divorced Separated

Patient Social Sec. Number: _____ Patient's Home Phone (____) _____

Patient's Address: _____
Street City State ZIP

Patient's Employer: _____ Work Phone: (____) _____

Employer's Address: _____
Street City State ZIP

Email Address: _____ May we send you an email newsletter YES

Emergency Contact: _____ 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?	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa Drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates?	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives.....	<input type="checkbox"/>	<input type="checkbox"/>
Iodine?	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin?	<input type="checkbox"/>	<input type="checkbox"/>
Latex rubber?	<input type="checkbox"/>	<input type="checkbox"/>
Any metals (e.g. nickel, mercury)?	<input type="checkbox"/>	<input type="checkbox"/>
Codeine?	<input type="checkbox"/>	<input type="checkbox"/>
Other? (Please list) _____	<input type="checkbox"/>	<input type="checkbox"/>

Physician's name: _____ Phone: _____

Date of last exam: _____

Are you under medical treatment now?..... YES NO

Have you been hospitalized for any serious illness within the last 5 years?..... YES NO
Please explain: _____

Are you pregnant, or think you may be?

Are you taking any medication(s), including

Non-prescription medicine?..... YES NO

Do you use tobacco products?

Do you use controlled substances?..... YES NO

Have you ever taken any bone building medicines?..... YES NO

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	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Easily winded	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever/Rheumatic Heart Disease.	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis/Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/allergies...	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking blood thinners?.	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/seizures	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Recent weight loss ...	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Joint replacement/implant	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis / Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory problems.	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Bleed easily?.....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problem	<input type="checkbox"/>	<input type="checkbox"/>	Stomach problem / ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>

Patient Dental History

Name of previous dentist and location: _____ Date of last Exam _____

	YES	NO		YES	NO
Do you gums bleed while brushing?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have frequent headaches?.....	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to hot or cold?	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to sweet or sour?	<input type="checkbox"/>	<input type="checkbox"/>	Do you bite your lips or cheek frequently?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any sores/ lumps in/near your mouth? ..	<input type="checkbox"/>	<input type="checkbox"/>	Have you had difficult extractions before?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any head, neck, or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had prolonged bleeding after extractions? ..	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever experienced any of the following in your jaw?

<input type="checkbox"/> Difficulty opening or closing	<input type="checkbox"/> Clicking
<input type="checkbox"/> Pain (joint, ear, side of face)	<input type="checkbox"/> Difficulty chewing

Do you wear dentures/partials?

Do you wear dentures/partials?

Date of placement _____

Have you ever had instruction on the care of your teeth? ... YES NO

Do you like your smile?..... YES NO

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.

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

_____ Date _____ Signature of doctor