Date _____

Patient Information

Name _____
Last First MI Preferred Name

Birth date: ____/____/____ Age:_____ SS#:_____
____ Single ____ Married ____ Divorced ____ Widowed ____ Separated

Address _____
Street Apt #

_____
City State Zip

Home Phone#: ( )_____-_____ Pager/Cell#: ( )_____-_____

Work #: ( )_____-_____ext_____ Email:_____

Fax#: ( )_____-_____

Employer:_____ Occupation:_____
Address:_____
How Long There?_____
How did you hear about or office? ___Yellow Pages ___ Newspaper
___ Radio ____ Another Patient? If so who? _____
___ Other, please list _____

Spouse Information

Name:_____
Employer:_____

Wk #: ( )_____-_____ext_____ SS#:_____
Birth date:____/____/_____

Neighbor or Relative not living with you

Name:_____ Relation:_____
Address:_____

Wk #: ( )_____-_____ Home#: ( )_____-_____

Dental Insurance Information

Insured's Name:_____
Address _____
Street Apt #

_____
City State Zip
Insured's Birth date:____/____/_____
Insured's SS#:_____
Insured's Employer:_____
Insurance Co. Name:_____

**For patients with insurance —We will file your claim at no charge and accept assignment of benefits from your primary carrier only. For those who have secondary insurance, we will file your claim and make benefits payable to the insured.

Dental History

Previous Dentist's Name _____
Date of last dental visit_____
For what treatment? _____
Does dental treatment make you nervous?
___No ___Slightly ____Moderately ___Extremely
Have you had any serious trouble associated with previous dental treatment? ___No ___Yes, Explain
_____
Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)?___ No ___ Yes, When?_____
Do you have or have you ever had any of the following (Check boxes that apply to you):

- ☐ Bleeding/Sore gums
- ☐ Unpleasant Taste/Bad breath
- ☐ Burning Tongue/Lips
- ☐ Frequent Blisters on Lips/Mouth
- ☐ Orthodontic Treatments (Braces)
- ☐ Swelling/Lumps in Mouth
- ☐ Biting Cheeks/Lips
- ☐ Clicking/Popping Jaw
- ☐ Difficulty Opening or Closing Jaw
- ☐ Loose Teeth
- ☐ Sensitive to Hot
- ☐ Sensitive to Cold
- ☐ Sensitive to Sweets
- ☐ Sensitive to Biting
- ☐ Food Impaction
- ☐ Clenching/Grinding Teeth
- ☐ Shifting of Teeth
- ☐ Change of Bite

Do you use the following?

- ☐ Brush ____ Soft ___ Medium ___ Hard
- ☐ Dental Floss How often? _____
- ☐ Fluoride Rinse Type? _____
- ☐ Other _____

How often do you brush?_____

Cosmetic/Esthetic Evaluation

Are you delighted with your smile? _____ Yes _____ No
Please rate your smile from 1 to 10 _____
(1=I hate my smile, 10= awesome)
What would you change about your smile? _____
_____
_____
Are you interested in whitening your smile? _____

On a scale of 1-10 (10 being highest) How important is your dental health to you? _____
Do you think it is important to have your teeth cleaned every 6 months? _____

What is most important about your relationship with Dr. Baluyut? _____
_____

Medical History

Do you have a personal physician? _____Yes _____No
Physician's Name:_____
Address:_____
Street
_____
City State Zip
Phone#: ( )_____-_____ Date of last visit:_____
Your Current Physical Health is: _____Good _____Fair _____Poor
Are you currently under the care of a physician?____ Yes _____No
If yes, for what conditions:_____
_____
Do you smoke or use tobacco in any other form? ____Yes ____No
Have you ever responded adversely to medical or dental
Treatment?_____
Are you taking any medication at this time? _____Yes _____No
If yes, please list_____
_____
_____
_____
_____

Do you have any drug allergies or have you ever had an adverse reaction to any medication?_____ Yes _____ No If so, list names of medications _____
_____
Is there anything else we should know about your medical history?
_____ Yes _____ No If yes, explain: _____
_____
_____
_____
_____

Do you have or have you ever had any of the following?
(Check boxes that apply to you):

- ☐ A.I.D.S.
- ☐ Allergies to Anesthetics
- ☐ Allergies to Latex
- ☐ Allergies to Medicines
- ☐ Arthritis
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chronic Diarrhea
- ☐ Circulatory problems
- ☐ Diabetes
- ☐ Epilepsy
- ☐ General Allergies
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Immunosuppressive Disorder
- ☐ Jaundice
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Nervous Problems
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Recent weight loss
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Neck Glands
- ☐ Thyroid Disease
- ☐ Ulcer
- ☐ Venereal Disease

For Women:
Are you Pregnant or suspect that you are? ____Yes ____No
When are you due? _____
Are you nursing? Yes No

Office Information

APPOINTMENTS:
Please understand that it is important for you to keep your scheduled dental appointments to maintain optimal dental health. Postponing treatment could compromise your condition resulting in discomfort and additional costs.

Your appointment time is set aside especially for you. We strive to stay on time and ask you to be on time for your appointments. We ask that if you have a change in your schedule and wish to change your appointment, please contact us 48 hours in advance so that we can schedule another appointment for you as soon as possible and make your time available to another patient waiting for an appointment.

Repeated cancellations or broken appointments without a 48-hour notice could result in a broken appointment charge or no reappointment.

PAYMENT:
We have several payment options available to you. These options are described in length on our Financial Menu. Please ask if you have any questions.

We realize that many families are in a state of change. The policy in our office is the parent who presents with the patient for treatment is responsible for payment.

INSURANCE:
We will file your claim for you at no charge. We will estimate a portion that insurance typically pays with the understanding that your plan could pay more or less. Any difference between our estimate and the amount actually paid is due from the patient.

BILLING:
We have established a financial menu aimed at trying to keep billing costs to a minimum. For patients with a balance after insurance, payment is due within 60 days. A 1½% monthly finance charge will be added to all balances that are 60 days overdue.

Patient Consent & Authorization

I affirm that the above information I have given is correct to the best of my knowledge and will be used for treatment, billing, and processing of insurance claims. I will not hold my dentist or any staff member responsible for any omissions or errors that I may have made in the completion of this form. I understand that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for all costs of dental treatment or any services rendered.

Patient Signature _____ Date _____

Office Use Only

I reviewed the medical/dental information of this patient named here in.
Date _____ Signature _____
Patient ID #_____