DM FAMILY DENTISTRY

Welcome

We are pleased to welcome you to our office.
Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Last Name:_____ First Name: _____ Soc. Sec. # _____
Address_____ City:_____ State:____ ZIP:_____
Home Phone#_____ Cell Phone#_____ E-mail:_____
Sex □M □F Age___ Birthdate_____ □Single □Married □Widowed □Separated □Divorced
Patient Employed By:_____ Occupation:_____
Business Address: _____ Business Phone: _____
Whom may we thank for referring you? _____
Notify in case of emergency: _____ Home Phone:_____ Work phone:_____
Cell Phone: _____ Business E-mail: _____

Primary Insurance

Person responsible for Account:_____
Relation to Patient:_____ Birth Date: _____ Soc. Sec.# _____
Address (if different from patient)_____ City: _____
State: _____ ZIP:_____ Home Phone# _____Cell# _____
E-mail: _____
Person responsible Employed by:_____ Occupation: _____
Business Address_____ Business Phone#_____
Business E-mail: _____
Insurance Company: _____ Phone# _____
Contact # _____ Group #_____ Subscriber's # _____
Name(s) of other dependents under this plan: _____
_____

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Additional Insurance

Is Patient covered by additional insurance? □ Yes □ No

Subscriber's Name:_____ Relation to Patient:_____ Birth date: _____

Address (if different from patient's)_____ Soc. Sec.# _____

City:_____ State _____ ZIP: _____Home Phone #_____

Cell Phone # _____ Business Phone # _____

Subscriber Employed by: _____ Business Email: _____

Insurance Company: _____ Phone# _____Email_____

Contact# _____ Group # _____ Subscriber's #_____

Name(s) of other dependents under this plan _____

What would you like to do today? _____

Are you in dental discomfort today? _____

Former Dentist:_____ Address _____

Phone # _____ Email: _____

Date of last dental care: _____ Date of last X-rays _____

Check Y for yes, or N for no, if you have or have not had the following:

□Y □N Bad Breath □Y □N Food collection between teeth □Y □N Sensitivity to cold

□Y □N Bleeding Gums □Y □N Loose teeth or broken fillings □Y □N Sensitivity to sweets

□Y □N Sensitivity to hot □Y □N Grinding or clenching teeth □Y □N Sensitivity when biting

□Y □N Clicking or popping jaw □Y □N Sores or growths in mouth

□Y □N periodontal treatment

How often do you brush? _____How often do you floss?_____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure □Y □N

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Medical History

Physician's Name:_____ Address: _____

Phone# _____ Email _____ Date of last visit: _____

Have you had any serious illnesses or operations □Y □N If yes describe:_____

Are you currently under physician care? □Y □N If yes describe: _____

Have you ever had a blood transfusion? □Y □N If yes give approximate dates _____

Have you ever taken Fen-Phen/Redux? □Y □N

Women: Are you Pregnant? □Y □N Nursing? □Y □N Taking birth control pills? □Y □N

Are you taking bilsphosphonates □Y □N

Check Y for YES or N for no if you have or not had any of the following:

□Y □N AIDS/HIV positive	□Y □N Jaw pain	□Y □N Anaphylaxis
□Y □N Venereal disease	□Y □N Liver disease	□Y □N Kidney disease or malfunction
□Y □N Arthritis, Rheumatism	□Y □N Shingles	□Y □N Back Problems
□Y □N Artificial heart valves	□Y □N Skin Rash	□Y □N Artificial joints
□Y □N Atopic (Allergy prone)	□Y □N Spina Bifida	□Y □N Blood disease
□Y □N Chemical dependency	□Y □N Scarlet fever	□Y □N Material allergies (latex, wool metal chemicals)
□Y □N Circulatory problems	□Y □N Diabetes	□Y □N Nervous problems
□Y □N Cortisone treatments	□Y □N Epilepsy	□Y □N Chemotherapy
□Y □N Cough, persistent	□Y □N Fainting	□Y □N Food allergies
□Y □N Cough up blood	□Y □N Glaucoma	□Y □N Heart problems describe_____
□Y □N High blood pressure	□Y □N Headaches	□Y □N Hemophilia / Abnormal bleeding
□Y □N Mitral valve prolapse	□Y □N Herpes	□Y □N Pacemeker / Heart surgery
□Y □N Respiratory disease	□Y □N Hepatitis	□Y □N Shortness of breath
□Y □N Rheumatic fever	□Y □N Tonsillitis	□Y □N Thyroid disease or malfunction
□Y □N Surgical implant	□Y □N Tuberculosis	□Y □N Swelling of feet or ankles
□Y □N Radiation treatment	□Y □N Ulcer/Colitis	□Y □N Tobacco habit
□Y □N Psychiatric care	□Y □N Stroke	□Y □N Rapid weight gain or loss
□Y □N Anemia	□Y □N Cancer	

List medications currently Taking:_____

List drug allergies:_____

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Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the Dentist Steven H. Dill to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: _____ Date: _____