Welcome to Bethesda Dental Center **2017**

Patient Information

Patients Name_____Cell Phone # _____

Address_____City/Zip _____

Home/Alter# _____ Email Address: _____

Sex: Male or Female Birthdate _____/_____/_____ Age: _____ Social Security# _____- _____- _____

Circle: Single Married Widowed Divorced Name of Spouse: _____

If Minor, Guardian /Parents Name _____ Social Security # ____-_____-_____

Address if different than patient _____

Preferred Contact # _____ Whom may we thank for this Referral? _____

BILLING INFORMATION IF NOT PATIENT

Responsible Party Name_____ Billing Address City/Zip _____

Employer Information

Employers Name_____Phone # _____

Insured Name _____Relationship to Patient _____Birthdate____/_____/_____
Insured's SS#____-_____-_____

Insurance Company Name_____ Group#_____

IN CASE OF EMERGENCY- CONTACT

Name_____ Contact #_____

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF THE BETHESDA DENTAL CENTER NOTICE OF PRIVACY PRACTICES. I ALSO UNDERSTAND THAT IF I DO NOT GIVE 48 HR NOTICE OF CANCELLATION AFTER 2nd Time within a six month period I will be dismissed from this practice . The Information on this page will be confidential .

_____ _____

Patient or Responsible Party Date

Reviewed medical history with no changes:

_____ _____

_____ _____

(Please Read and Sign the Back of this Form)

DENTAL HEALTH HISTORY

CONFIDENTIAL

Reason for TODAYS VISIT _____

NEW PATIENT: Former Dentist/ Approx. date of last Exam _____

CIRCLE if you have had problems with any of the following:

Bad Breath	Food Collecting between teeth	Sensitivity to Hot/Cold
Bleeding gums	Grinding teeth	Sensitivity to sweets
Clicking/popping Jaw	Jaw Pain	Sensitivity when biting
Do you like looks of your teeth	loose teeth or broken fillings	Sores in your mouth

How often do you floss? _____ How often do you brush? _____Do you like the way your smile looks? Yes No

Medical History

Physicians Name + Date of last Visit _____

Have you had any serious illnesses or operations? Yes No If yes, Describe_____
Has there been any change in your general health in the last year? Yes No
Do you use tobacco? Yes No If yes, smoker or smokeless

Circle if you have or had any of the following:

Abnormal Bleeding	Chemical Dependency	Hemophilia	Scarlet Fever
Chemical Allergies	Chemotherapy	Hepatitis	Shortness of Breath
Anemia	Cortisone Treatments	High/Low Blood Pressure	Stroke
Arthritis /Rheumatism	Cough up blood	HIV/AIDS	Swelling of Feet/Ankles
Artificial Heart Valves	Diabetes	Kidney Disease	Thyroid Problems
Artificial Joints	Epilepsy	Liver Disease	Tobacco Habit
Asthma	Fainting	Mitro-Valve Prolapse	Tonsillitis
Back Problems	Headaches	Pacemaker	Tuberculosis
Blood Disease	Heart Murmur	Respiratory Disease	Veneral Disease
Cancer	Heart Problems	Rheumatic Fever	Skeletal Bone Loss

Taking Any Medications? Yes No

If yes, List medications you are currently taking: _____

ALLERGIES: Yes No If Yes, please list _____

(WOMEN) ARE YOU PREGNANT? Yes No Taking Birth Control YES NO

(Please Read and Sign the Back of this Form)