Welcome To Our Practice

We strive to be great relationship builders. One of our top priorities is taking the time to get to know you - offering a listening ear and treating you as a person rather than just another set of teeth to clean and fix. Why? Because in today's fragmented world it might seem that dental health and overall well-being aren't related. We are certain that they are.

Patient Information

Patient Name: ______________________________ Date: ____________
Last First MI Preferred Name

☐ Male ☐ Female ☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Social Security #: ____________ DOB: __________ Email: ______________________

Phone (Home): ______________ (Work): ______________ (Cell:) ______________

Your Address: ____
Street City Zip Code

Employer Name: ______________________ Occupation: ______________________

Emergency Contact: __________ Phone: __________ Cell: __________ Relation: __________

Health Information

Have you ever had any of the following? Please check those that apply:

☐ Allergies to: ________
- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Jewelry / Metals
- ☐ Latex
- ☐ Penicillin
- ☐ Tetracycline
- ☐

Other ____________
____

☐ Anemia
☐ Arthritis
☐ Artificial Joints/Valves

☐ Asthma
☐ Blood Tranfusion
☐ Cancer/Chemotherapy
☐ Diabetes
☐ Dental Anxiety
☐ Epilepsy / Seizures
☐ Emphysema
☐ Excessive Bleeding
☐ Fever Blisters / Herpes
☐ Glaucoma
☐ Heart Attack / Stroke
☐ Heart Murmur
☐ Heart Surgery / Pacemaker
☐ Hepatitis
☐ High / Low Blood Pressure

☐ HIV / AIDS
☐ Hospitalization
☐ Jaundice
☐ Kidney Problems
☐ Liver Problems
☐ Mitral Valve Prolapse
☐ Nervous Disorders
☐ Oral Cancer
☐ Phen-Fen Diet Pills
☐ Psychiatric Care
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Severe Headaches
☐ Sickle Cell Disease

☐ Sinus Problems
☐ Current Smoker/Dipper
☐ Tuberculosis (TB)
☐ Tumors
☐ Ulcers / Colitis
☐ Venereal Disease
☐ Do you have Sleep Apnea?

Other:
☐ ____________
☐ ____________
☐ ____________

Women:
☐ Are You Pregnant?
☐ No ☐ Yes #of Weeks ___

- Do you have any health problems that need clarification? ☐ Yes ☐ No
  If yes, please explain: ______________________
- Do you require antibiotic premedication ☐ Yes ☐ No
- Name of Physician: ______________________ Phone: ______________
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ______________________
- Please list **any** prescription, over-the-counter drugs, vitamins, or herbal supplements you are taking **ON THE NEXT PAGE**.
- Whom may we thank for referring you to our practice? Another patient, friend, or relative ☐ Dental Office
  ☐ Internet ☐ Yellow Pages ☐ Newspaper / Magazine ☐ School ☐ Work ☐ Other ____________
  ☐ Name of person or office referring you to our practice: ______________________

By signing, I attest to the accuracy and truthfulness of the information provided.

- **In accordance with HIPAA, by signing below, I authorize the release of information regarding my dental treatment (or my minor child or dependent) to referring care providers and insurance carriers or a designated family member. Designated family member name:** ______________________

______________________________ ______________________________
Signature of patient, parent or guardian Date Signature of Dental Staff Member

Dental Information

Why have you come to the dentist today? ____

- ☐ Yes ☐ No Has your doctor ever told you that you require antibiotics before dental treatment?
- ☐ Yes ☐ No Have you ever had a serious / difficult problem associated with any previous dental work?
- ☐ Yes ☐ No Do you have, or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)?
- ☐ Yes ☐ No Are you currently having dental pain? ☐ Yes ☐ No Have you ever had a toothache?
- ☐ Yes ☐ No Have you ever fractured or cracked a tooth?
- ☐ Yes ☐ No Are you concerned about your silver / mercury fillings?
- ☐ Yes ☐ No Have you noticed spots, stains or chips on your teeth that concern you?
- ☐ Yes ☐ No Are you pleased with the appearance of your smile?
- ☐ Yes ☐ No Have you ever considered whitening your teeth?
- ☐ Yes ☐ No Have you ever considered straightening your teeth?
- ☐ Yes ☐ No Do you have any place where food catches between your teeth or areas that are difficult to floss?
- ☐ Yes ☐ No Have you ever been told that you have, or have you ever been treated for, gum disease (pyorrhea)?
- ☐ Yes ☐ No Do your gums ever bleed?

How many times a day do you brush your teeth? ____________ What do you use to clean between your teeth? ________

How would you rate your dental health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What is your curent Height? _____________ Weight? ______________ Date of last cleaning/exam: ______________

What do you like most about any dentist you have seen? ___________________________ Least? ______________

Why did you leave your previous dentist? ____

PERSON RESPONSIBLE FOR ACCOUNT

Name: ___________________________________ DOB: ____________________ SSN: ___________________________

Address: ____

Phone (Home): _______________________________________ (Cell:) ____

Employer Name: ____Work Phone: _______________________________

Relationship to Patient: ____

Insurance Information

Name of Insured: __________________________________ DOB: ___________________ SSN: ___________________

Insured's Address: ____ Phone: __________________

Insured's Employer Name: _______________________________________ Phone: ______________________________

Insurance Company Name: ____ Phone: ________________________

Group #: _______________________________________ Insured's ID #: _______________________________________

Consent of Service

With my signature below, I authorize:

- the dental staff of TROY FAMILY DENTAL to perform any necessary dental services required during my diagnosis and treatment, with my informed consent.
- the release of any information necessary to process insurance claims.
- if I request payment arrangements for services rendered, the generation of a credit report
- by signing, I attest to the accuracy and truthfulness of the information provided.

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Signature of patient, parent or guardian Date