About You

Patient's Name _____ I prefer to be called _____ Date _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Social Security # _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Phone# _____ Work Phone # _____ Ext._____ Cell # _____ Driver License # _____

If a child, Parent's Name _____ Full-time Student? ☐ Yes ☐ No If yes, where? _____

Patient/Parent Employer _____ Present Position/Department _____

Business Address _____

Name & phone # of nearest relative? _____ Whom may we thank for referring you? _____

Person responsible for this account? [Patient] [Other _____]

Spouse Information

His/Her Name _____ Date of Birth _____ Social Security # _____

Employer _____ Work Phone # _____ Ext. _____

Insurance Information

Primary Insurance

Insurance Co. Name _____ Phone # _____ Group/Policy # _____

Insurance Co. Address _____
Street/PO Box City State Zip

Insured's Name & BD _____ Relation [Self] [Spouse] [Other-_____]

Insured's Employer & Address _____
Street/PO Box City State Zip

Secondary Insurance

Insurance Co. Name _____ Phone # _____ Group/Policy # _____

Insurance Co. Address _____
Street/PO Box City State Zip

Insured's Name & BD _____ Relation [Self] [Spouse] [Other-_____]

Insured's Employer & Address _____
Street/PO Box City State Zip

Dental History

Are you now having discomfort or pain? ☐ Yes ☐ No

Do you need to be premedicated before treatment? ☐ Yes ☐ No

Do you now, or have you ever experienced pain/discomfort in your jaw joint? ☐ Yes ☐ No

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No

In case of emergency, who may we contact? _____
Relation & Phone #: _____

Reason for your visit today?

Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had periodontial disease? ☐ Yes ☐ No

Do you have any loose teeth? ☐ Yes ☐ No

Are your teeth sensitive to heat, cold, or anything else? _____

Previous/Present Dentist _____ Last visit _____

What was done for you at that time? _____

Are you happy with the way your smile looks? _____

If not, what would you change? _____

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

Please explain: _____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Are you allergic to any of the following?

Y N	Aspirin	Y N	Erythromycin	Y N	Sedatives
Y N	Barbiturates	Y N	Jewelry/Metals	Y N	Sulfa Drugs
Y N	Codeine	Y N	Latex	Y N	Tetracycline
Y N	Dental Anesthetics	Y N	Penicillin	Y N	Other

Please list additional drugs that cause allergic reactions: _____

_____

For Women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Unsure ☐ Yes ☐ No

Week #: _____ Are you nursing? ☐ Yes ☐ No

Are you taking any of the following?

Y N	Acetaminophen	Y N	Blood Thinners	Y N	Insulin/Diabetes Drugs	Y N	Thyroid Medicine
Y N	Antibiotics	Y N	Blood Pressure Medication	Y N	Nitroglycerin	Y N	Tranquilizers
Y N	Antihistamines	Y N	Cold Remedies	Y N	Recreational Drugs		
Y N	Aspirin	Y N	Heart Medication	Y N	Steroids/Cortisone		

Are you taking any prescription/over-the-counter-drugs not listed above? ☐ Yes ☐ No If yes, please list each one: _____

_____

Do you currently have or have you experienced any of the following?

Y N	Abnormal Bleeding	Y N	Colitis	Y N	Headaches	Y N	Liver Disease	Y N	Shingles
Y N	Alcohol Abuse	Y N	Congenital Heart Defect	Y N	Heart Attack	Y N	Low Blood Pressure	Y N	Sickle Cell Disease
Y N	Anemia	Y N	Diabetes	Y N	Heart Murmur	Y N	Lupus	Y N	Sinus Problems
Y N	Arthritis	Y N	Difficulty Breathing	Y N	Heart Surgery	Y N	Mitral Valve Prolapse	Y N	Steroid Therapy
Y N	Artificial Bones/Joints	Y N	Drug Abuse	Y N	Hemophilia	Y N	Pacemaker	Y N	Stroke
Y N	Artificial Valves	Y N	Emphysema	Y N	Hepatitis	Y N	Persistent Cough	Y N	Thyroid Problems
Y N	Asthma	Y N	Epilepsy	Y N	Herpes	Y N	Psychiatric Problems	Y N	Tonsillitis
Y N	Blood Transfusion	Y N	Fainting Spells	Y N	High Blood Pressure	Y N	Radiation Treatment	Y N	Tuberculosis (TB)
Y N	Cancer	Y N	Fever Blisters	Y N	HIV+/Aids	Y N	Rheumatic Fever	Y N	Ulcers
Y N	Chemotherapy	Y N	Glaucoma	Y N	Hospitalized ?	Y N	Scarlet Fever	Y N	Venereal Disease
Y N	Chicken Pox	Y N	Hay Fever	Y N	Kidney Problems	Y N	Seizures		

Please list any serious medical condition(s) that you have experienced, or any problem not listed above: _____

_____

Authorizations

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

My method of payment will be (Cash, Check, Visa, MC, Discover)
(circle one)

Credit/Debit Card # _____ Exp. Date _____
(optional)

X_____
Signature Date

BCBS, Delta Dental, & Metlife Patients I certify that I have BCBS dental insurance and understand that all insurance payments will be paid directly to Northeast Columbia Family Dentistry.

I agree to pay for all treatment charges for myself and/or my dependent, regardless of what my benefits may or may not pay. I understand insurance is a contract between the insurance company and myself, and that the dentist is a third party filing claims on my behalf. **I understand that I am responsible to pay, at each visit, any co-payment and/or deductible that my insurance doesn't cover.** I hereby authorize the dentist to release all information necessary to secure the payment of benefits and to use this signature on all claim submissions on my behalf.

X_____
Signature Date