

# ADULT INFORMATION FORM

Name _____	Primary Physician _____
Social Security # _____	D.O.B. _____
Address _____	Home Phone _____
City _____	Work Phone _____
State _____ Zip Code _____	Cell Phone _____
	Email _____

## INSURANCE DETAILS

Policy Holder _____	Relationship _____
D.O.B. _____	Social Security# _____
Carrier _____	Policy Number _____
Phone Contact _____	Employer _____

NOTE: It is your responsibility to be aware of your policy guidelines regarding dental care. To provide prompt reimbursement, please provide any changes or updates to your policy. We will provide complete information to your insurance company to ensure you receive optimum reimbursement for the procedures you accept.

Source of Referral \_\_\_\_\_

Primary Concern \_\_\_\_\_

***Do we have permission to: (please check one)*** **YES**      **NO**

Leave a message at home or work regarding your appointment in our office? \_\_\_      \_\_\_

Leave a message at home regarding the results of a biopsy or lab results? \_\_\_      \_\_\_

Discuss your dental condition with any member of your household?  
(state which) HWMFCO \_\_\_      \_\_\_

Mail a postcard or letter to your home to notify you of an appointment in our office? \_\_\_      \_\_\_

Contact your medical doctor regarding any treatment you may require? \_\_\_      \_\_\_

Contact your pharmacist if you require a prescription? \_\_\_      \_\_\_

Allow your photograph to be displayed for educational purposes? \_\_\_      \_\_\_

In order to provide efficient and comprehensive care, time is set aside for each patient individually. We will be prepared and on time for your visit. We insist patients understand all aspects of their treatment, the cost, and the reason for the recommendations. Once you ask us to reserve time in our schedule, we anticipate you will have respect for the team and their commitment to your care. Failure to provide 2 (two) business days notice of schedule changes may result in a charge of \$25 per reserved half hour of time.

**SIGNED** \_\_\_\_\_ **DATE** \_\_\_\_\_

## Dental History

When was your last visit to the dentist? \_\_\_\_\_

What was done? \_\_\_\_\_

How often do you visit a dentist? \_\_\_\_\_

How recently was a complete series of radiographs taken? \_\_\_\_\_

List all medications you are taking \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Previous Dental Experience

\_\_\_ Oral surgery \_\_\_ injury/surgery to face or jaw?

\_\_\_ Dentures Upper or Lower \_\_\_ root canal

\_\_\_ periodontal therapy \_\_\_ fixed bridges

\_\_\_ crowns, veneers or implants? \_\_\_ orthodontics/appliances

## TMJ

YES NO

\_\_\_ \_\_\_ Do you frequently awaken with headaches?

\_\_\_ \_\_\_ Are you aware if you grind or clench your teeth?

\_\_\_ \_\_\_ Has it been difficult for you to open or close your mouth?

\_\_\_ \_\_\_ Have you heard clicking/popping sounds when chewing?

\_\_\_ \_\_\_ Has a dentist adjusted the way your teeth come together?

\_\_\_ \_\_\_ Are you aware of any loose teeth?

## Periodontal

YES NO

\_\_\_ \_\_\_ Are there any sore spots in your mouth?

\_\_\_ \_\_\_ Are your gums swollen or tender?

\_\_\_ \_\_\_ Do you experience a bad taste or odor in your mouth?

\_\_\_ \_\_\_ Do your gums bleed when eating or brushing?

\_\_\_ \_\_\_ Are any teeth sensitive to heat, cold or pressure?

\_\_\_ \_\_\_ Does food frequently get caught between your teeth?

What role does stress play in your life?

(Minor) (Major)

1 2 3 4 5

How would you rate your oral health?

(Poor) (Excellent)

1 2 3 4 5

Is there anything that you would like to change about the shape or color of your teeth? \_\_\_\_\_

\_\_\_\_\_

Have you ever wanted to know more about:

\_\_\_ whitening? \_\_\_ veneers? \_\_\_ implants? \_\_\_ cosmetic options?

**How would you rate your overall physical wellness?**

**Poor Fair Good Excellent**

Has there been a negative experience with past dentistry that you would like to share?

## Health History

YES NO

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Have you been treated by an MD in the past 2 years?

Recently/Currently taking any prescription or non prescription drugs?

Are you taking birth control pills?

Are you pregnant? Due Date? \_\_\_\_\_

Have you ever reacted adversely to pain killers, anesthetics, antibiotics?

Has antibiotic coverage been prescribed for dentistry?

History of mitral valve prolapsed or heart murmur?

Do you have asthma, hay fever or sinus trouble?

Do you have epilepsy?

**Have you had surgery for: (Check those that apply)**

\_\_\_ Organ transplant? \_\_\_ Rheumatic/scarlet fever?

\_\_\_ Joint replacement? \_\_\_ Heart disease?

**Have you ever had: (Check those that apply)**

\_\_\_ Heart attack? \_\_\_ Stroke?

\_\_\_ Diabetes? \_\_\_ Pace Maker?

\_\_\_ High Blood Pressure? \_\_\_ Low blood pressure?

**Do you have: (Check those that apply)**

\_\_\_ Cancer? \_\_\_ Kidney Disease? \_\_\_ MS?

\_\_\_ TB or lung disease? \_\_\_ Hodgkins disease?

\_\_\_ Fibromyalgia? \_\_\_ Chronic Fatigue

\_\_\_ Lupus?

YES NO

\_\_\_ \_\_\_

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\_\_\_ \_\_\_

Do you have/had in the past any disease not mentioned above?

\_\_\_\_\_

The above personal, dental and medical history is complete and accurate, and I have not knowingly withheld information. I authorize the dentist to perform diagnostic procedures and administer treatments. I will be presented options, and allowed to ask questions. I take full responsibility for payment for all procedures during treatment regardless of dental insurance.

SIGNED

DATE