ABOUT YOU

Patient Name ______________________________ Today's Date ____________
Last First MI

What do you prefer to be called? ______________________________

Birthdate ____ /____ /____ Age __________ SS# ______________

Mailing Address ______________________________ Home Phone (____) ____________

______________________________ Work Phone (____) ____________

Email ______________________________ Cell Phone (____) ____________

How did you hear about us? ______________________________

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

Company Name ______________________________

Address ______________________________

____

Phone # (____) ______________________________

Group # (Plan, local, or policy #) ____________

Insured's Name ______________________________

Relation ____________ DOB ____/____/____

Insured's SS # ______________________________

Insured's Employer ______________________________

SECONDARY DENTAL INSURANCE

Company Name ______________________________

Address ______________________________

____

Phone # (____) ______________________________

Group # (Plan, local, or policy #) ____________

Insured's Name ______________________________

Relation ____________ DOB ____/____/____

Insured's SS # ______________________________

Insured's Employer ______________________________

ACCOUNT INFORMATION (PERSON ULTIMATELY RESPONSIBLE FOR ACCOUNT)

Name ______________________________ Relation ______________________________

Billing Address ______________________________ Phone # (____) ______________________________

______________________________ SS # ______________________________

Payment Method ☐ Cash ☐ Check ☐ Credit Driver's License # ______________________________

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balances not paid by my insurance company.

Signature ______________________________ Date ______________________________

EMERGENCY EVENT

Whom do we contact? ______________________________ Relation ______________

Home Phone (_____)________________ Work Phone (_____)________________

Email ______________________________ Cell Phone (_____)________________

Who is your doctor? ____________________ Physician's Phone # (_____)____________

Preferred Pharmacy ____________________ Pharmacy Phone # (_____)____________

DENTAL INFORMATION

Reason(s) for today's visit: ☐ New Patient ☐ Emergency ☐ 6 Month Cleaning/Check Up

Are you in pain? ☐ Yes ☐ No If yes, how long? ______________________________

Please indicate any of the following problems:

YES	NO		YES	NO	
☐	☐	Bad breath	☐	☐	Locking jaw
☐	☐	Blisters/sores in mouth	☐	☐	Red, swollen, bleeding gums
☐	☐	Broken or chipped teeth	☐	☐	Sensitive teeth or gums
☐	☐	Broken or lost fillings	☐	☐	Stained teeth
☐	☐	Discomfort, clicking, popping in jaw	☐	☐	Teeth Grinding
☐	☐	Food stuck in teeth	☐	☐	Other ______________________

Do you require pre-medication? ☐ Yes ☐ No If yes, why? ______________________________

Previous Dentist ____________________ Phone (_____)________________

Last Dental Exam ____________________ Last Dental X-Rays ________________

What type of toothbrush do you use? ☐ Soft ☐ Medium ☐ Hard

How many times a day do you brush? __________ How many times a week do you floss? __________

How would you rate your smile from 1 to 10? (WORST) 1 2 3 4 5 6 7 8 9 10 (BEST)

What would you like to change about your smile? ______________________________

____

Do you have any other comments, questions, or concerns about your dental visit? ______________

____

____

____

PEAKDENTAL
COSMETIC & FAMILY DENTISTRY

MEDICAL INFORMATION

Are you taking any of the following medications? (Check all that apply.)

- ☐ Anti-Anxiety
- ☐ Aspirin
- ☐ Blood Thinners
- ☐ Chemotherapy
- ☐ Insulin
- ☐ Muscle Relaxers
- ☐ Osteoporosis/Bone Medication
- ☐ Pain Killers
- ☐ Stimulants
- ☐ Tranquilizers

Please list any other medications. ____

____

Do you have or have you had any of the following medical conditions or procedures?

YES	NO	
☐	☐	Alcohol/Drug Abuse
☐	☐	Anemia
☐	☐	Arthritis/Rhuematism
☐	☐	Artificial Valves
☐	☐	Asthma/Difficulty Breathing
☐	☐	Back Problems
☐	☐	Bleeding Problems
☐	☐	Cancer
☐	☐	Chemotherapy
☐	☐	Chest Pains
☐	☐	Congenital Heart Disease
☐	☐	Cosmetic Surgery
☐	☐	Diabetes/Hypoglycemia
☐	☐	Emphysema
☐	☐	Glaucoma
☐	☐	Heart Attack/Stroke
☐	☐	Heart Disease
☐	☐	Heart Murmur
☐	☐	Heart Surgery
☐	☐	Hepatitis
☐	☐	High/Low Blood Pressure
☐	☐	HIV+/AIDS/ARC
☐	☐	Jaw Problems
☐	☐	Kidney Problems
☐	☐	Leukemia
☐	☐	Liver Problems
☐	☐	Migraines/Headaches
☐	☐	Mitral Valve Prolapse
☐	☐	Nervousness
☐	☐	Pacemaker
☐	☐	Psychiatric Problems
☐	☐	Respiratory Problems
☐	☐	Rheumatic Fever
☐	☐	Scarlet Fever
☐	☐	Seizures/Fainting
☐	☐	Shingles
☐	☐	Stomach Problems
☐	☐	Thyroid Problems
☐	☐	Tuberculosis (TB)
☐	☐	Veneral Disease

Please list any other medical conditions or surgeries you have or have ever had. ________________

____

Are you allergic to any of the following? (check all) ☐ Penicillin ☐ Amoxicillin ☐ Latex ☐ Tetracycline ☐ Local Anesthetic

Do you use tobacco products? ☐ Yes ☐ No How many packs/day and how long? ____________

Please rate your general health from 1-10. ____________ Do you wear contact lenses? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No How many children have you had? __________

Are you pregnant? ☐ Yes ☐ No If yes, how many weeks? _______ Are you nursing? ☐ Yes ☐ No