

PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name _____
Last First MI (Preferred)
Birthdate _____ SS# _____ Gender: M F Married: Y N
Work Phone _____ Wireless Phone _____ Wireless Carrier _____
Email _____
Preferred contact method HmPhone WkPhone WirelessPh Email
Preferred contact method for confirmations HmPhone WkPhone WirelessPh Email
Preferred contact method for recall HmPhone WkPhone WirelessPh Email
Student status if dependent over 19 (for ins) Nonstudent Fulltime Parttime
How did you hear about us?

(If someone referred you here, please write down their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family
Address _____
Address 2 _____
City _____ State _____ Zip _____
Home Phone _____

INSURANCE POLICY 1

Your relationship to subscriber: Self Spouse Child
Subscriber Name _____ Subscriber ID # _____
Insurance Company _____ Phone _____
Employer _____ Group Name _____ Group # _____
Please present insurance card to receptionist.

INSURANCE POLICY 2

Your relationship to subscriber: Self Spouse Child
Subscriber Name _____ Subscriber ID # _____
Insurance Company _____ Phone _____
Employer _____ Group Name _____ Group # _____

Comments:

Medical History

Last Name: _____ First Name: _____ Birthdate: _____
Name of Medical Doctor _____ Phone: _____
Emergency Contac _____ Phon _____ Relationshi _____
What Pharmacy do you use? _____ Phone #: _____

List ALL medications that you are now taking, INCLUDING Over the Counter:

1-No Medication

- Are you now under current medical treatment? Explain: N
- Have you had any recent medical surgeries? Explain: N
- Do you have any allergies? Medication or others? N
- Have you ever had hip or joint replacement? N
- Do you take premedication for dental treatment? N
- Do you have a heart murmur, heart valve defect or any heart conditions? N
- Do you have any circulatory problems? (high or low blood pressure, etc) N
- Have you ever had any x-ray/radiation treatment to the head and/or neck area?
- Have you ever experienced any complications with healing? Explain: N
- Have you ever taken Oral or IV Bisphosphirates for Osteoporsis? (Fosamax, Boniva, N
- Tobacco use?cigarettes,chew,etc.How much/often?

Do you have any of the following medical conditions? Currently or History of:

PLEASE CHECK YES OR NO TO THE FOLLOWING BOXES

- | Y | N | | Y | N | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis or Rheumatism | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse |
| <input type="checkbox"/> | <input type="checkbox"/> | Autism Spectrum | <input type="checkbox"/> | <input type="checkbox"/> | Nervous Disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | Acq. Immune Deficiency Synd.(AIDS/HIV) | <input type="checkbox"/> | <input type="checkbox"/> | Organ Transplants |
| <input type="checkbox"/> | <input type="checkbox"/> | Behavior/Social Concerns | <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy Due Date: |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Disease (anemia, hemophilia, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Disorders (asthma, etc.) |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer Type/Date: | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Ear Infections | <input type="checkbox"/> | <input type="checkbox"/> | Serious Head Injuries |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes Type | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Surgical Implant (joint, pacemaker, defibulato |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis Type | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Latex Sensitivity | <input type="checkbox"/> | <input type="checkbox"/> | Tumors or Growths |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease (jaundice, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | HPV |
| <input type="checkbox"/> | <input type="checkbox"/> | Other | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | In the unlikely event that a Ling Family Dentistry healthcare worker is exposed to my blood or body fluids through a needle stick, skin cut, or splash to the eyes/mouth area, I agree to have my blood tested (free of charge) for blood borne diseases to include Hepatitis and Human Immunodeficiency Virus (HIV) | | | |

Date: _____

Dental History ~ New Patients

Last Name:

First Name:

Birthdate:

Y N

- Do you take Premedication for Dental Treatment
- Do you have a toothache now? Explain:
- Do you have any growths or sores in your mouth
- Do your gums bleed easily?
- Have you ever had local anesthetic (novocaine)?
- Have you ever had any adverse reactions to local anesthetics?
- Have you ever had periodontal disease or gum disease?
- Do you habitually clench or grind your teeth during the day or nig
- Do you have pain in or near your ears?
- Have you ever been instructed in proper flossing and brushing technique
- Do you brush daily?
- Do you floss daily?
- Do you have City Water?
- Do you Filter your Water?

Is any part of your mouth sore to pressures (including biting) or irritants? (cold, heat, sweets, etc) Explain:

Non

Tobacco use? If so, what kind and how much

Reason for today's visi

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old

Do you have BiteWing x-rays that are less than 1 year old

Name of former dentis

City/Stat

Date of last cleaning and exa

Date:

Financial Agreement

Last Name:

First Name

Birthdate:

Date:

- * For my convenience, this office may release my information to my insurance company, and receive payment directly from them.
- * I understand that I am financially responsible for all charges whether or not paid by insurance.
- * I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.
- * If sent to collections, I agree to pay all related fees and court costs.
- * Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
- * I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.
- * I will pay a fee for appointments broken without 24 hours notice.
- * Treatment plans may change, and I will be responsible for the work actually done.