WELCOME TO PROFESSIONAL DENTAL GROUP

From whom did you hear about our office? _____

May we mention your name when thanking them?_____

NAME:_____Name preferred:_____Sex: □**M** □**F**

Birthdate:___/___/____ Marital Status: □ S □ M □ D □ W Phone:_____Cell Phone:_____

Address:_____City:_____State_____Zip_____

Email:_____

Occupation: _____Employed by:_____ Work phone:_____

SPOUSE:_____Birthday:_____/_____/_____ Cell phone:_____

Occupation:_____Employed by:_____ Work phone:_____

Emergency Contact Person:_____Phone:_____

Relationship to Patient:_____Cell Phone:_____

IF PATIENT IS A CHILD/DEPENDENT

Parent/Guardian:_____Birthdate:____/____/____ Cell phone:_____

Occupation:_____Employed by:_____ Work phone:_____

Parent/Guardian: _____Birthdate:____/____/____Cell Phone:_____

Occupation:_____Employed by:_____Work phone:_____

INSURANCE INFORMATION

Dental Insurance Co.: _____Group #:_____ID #:_____

Policy Holder:_____Employer:_____

HIPAA AUTHORIZATION (Patients 18yrs or older)

I give consent to discuss my personal dental records and appointments with the individual(s) listed below:

Name/Relationship: _____

ASSIGNMENT & RELEASE: I hereby authorize my insurance benefit payments to be assigned directly to Professional Dental Group. I also authorize the dentist to release any information required for the insurance claim.

FINANCIAL AGREEMENT: By signing I understand and accept that payment in full is due at the time of service, unless discussed and accepted by this office prior to services being provided. If there is dental insurance, we will **estimate** any co-payments or payments that will be due at the time of service. This is NOT a guarantee of benefits. Because of the number of patients and insurance plans, we are unable to know the specifics of your plan. We encourage you to become familiar with your own plan. You are responsible for any balances that remain on your account if the insurance does not pay as much as anticipated or they deny payment.

THANK YOU for choosing PROFESSIONAL DENTAL GROUP. Our goal is to offer you the best possible dental care and understanding of the dental treatment recommended to you.

SIGNATURE: (Parent/Guardian if Child/Dependent):_____DATE:_____/_____/_____

HEALTH HISTORY

Name:_____ Birthdate:_____

Physician/Clinic:_____ Office Phone:_____ Last physical exam:_____

YES NO

☐ ☐ 1. Are you taking any prescribed medication(s) Or any non-prescription drugs (i.e. vitamins)? If yes, please list:

_____

_____

_____

☐ ☐ 2. Do you use tobacco? Kind? _____

3. Are you allergic to or have you ever reacted to:

☐ ☐ • Local Anesthetics (e.g. Novacaine)?
☐ ☐ • Penicillin or other antibiotics?
☐ ☐ • Sulfa drugs?
☐ ☐ • Latex?
☐ ☐ • Aspirin or Codeine?
☐ ☐ • Metals (e.g. nickel)?
☐ ☐ • Other _____

4. **WOMEN ONLY**

☐ ☐ •Are you pregnant? Or think you might be?
☐ ☐ •Are you on birth control or hormone replacements?

5. Carefully read the following and **CHECK** any that have ever affected you and circle if a choice:

☐ High/Low blood pressure
☐ Heart attack-date_____
☐ Heart disease
☐ Heart bypass
☐ Cardiac pacemaker
☐ Heart murmur
☐ AIDS or HIV infection
☐ Fainting
☐ Seizures/Epilepsy
☐ Kidney disease
☐ Liver disease
☐ Thyroid problems
☐ Ulcers/stomach problems
☐ Respiratory problems
☐ Asthma
☐ Rheumatic fever
☐ Dental Implants
☐ Diabetes
☐ Arthritis
☐ Nightguard
☐ Heart Valve Replacement
☐ Cancer/Type_____date_____
☐ Radiation/chemotherapy
☐ Tuberculosis
☐ Stroke
☐ Artificial joint/limbs Type_____ date_____
☐ Pins/Plates – date_____
☐ Hepatitis
☐ Herpes
☐ Chemical dependency
☐ Glaucoma
☐ Loss of hearing
☐ Recent weight loss/gain
☐ Eating disorders
☐ Allergies
☐ Anemia
☐ Sleep Apnea CPAP/Oral Sleep appliance
☐ Memory issues/Dementia
☐ Acid Reflux
☐ Other _____
_____

DENTAL HISTORY

Last dental visit?_____ For: ☐ Exam ☐ Cleaning ☐ Toothache ☐ Other_____

How do you feel about going to the dental office? ☐ Fine ☐ Slightly nervous ☐ Very uncomfortable

YES NO

☐ ☐ 1. Do your gums bleed while brushing?
☐ ☐ 2. Are your teeth sensitive?
☐ ☐ 3. Are any of your teeth painful?
☐ ☐ 4. Have you had any head, neck or jaw injuries?
☐ ☐ 5. Do you grind or clench your teeth?
☐ ☐ 6. Have you ever been told you have TMJ?
☐ ☐ 7. Have you ever had any prolonged bleeding following dental extractions?

YES NO

☐ ☐ 8. Have you ever had braces/orthodontic work?
☐ ☐ 9. Have you ever been told you have gum disease?
☐ ☐ 10. Have you had periodontal treatment?
☐ ☐ 11. Do you wear a Nightguard?
☐ ☐ 12.Any other dental concerns:_____
_____
_____

SIGNATURE_____ **DATE**_____

Comments:

_____

_____