Town & Country DENTAL ARTS

WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1. ABOUT YOU

Name: LAST FIRST MI.			Today's Date:
E-Mail Address:	☐ Male ☐ Female		D.O.B Age:
Home Address: CITY STATE ZIP			SS #:
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated			DL #: State:
Mobile #: ( ) Work#: ( ) Ext: Home #: ( )			When & where are the best times to reach you?
Employer:	Years Employed There:	Occupation:	
Employer Address:			
Whom may we thank for referring you?		Other family members seen by us:	
Previous / Current Dentist:		Last Visit Date:	

2. SPOUSE INFORMATION AND ACCOUNT RESPONSIBILITY

Name: LAST FIRST MI.			SS #:
Relationship:	Employer:	D.O.B.:	DL #: State:
Mobile #: ( ) Work#: ( ) Ext: Home #: ( )			
Person Responsible for Account:		Relationship:	SS #:
Mobile #: ( ) Work#: ( ) Ext: Home #: ( )		Employer:	DL #: State:
Billing Address: CITY STATE ZIP			

3. DENTAL BENEFIT PLAN

Primary Benefit / Insurance Plan		**Secondary Benefit / Insurance Plan**	
Insurance Company Name:		Insurance Company Name:	
Address:	Phone #: ( )	Address:	Phone #: ( )
Group # (Plan, Local or Policy #):		Group # (Plan, Local or Policy #):	
Insured's Name:	D.O.B.	Insured's Name:	D.O.B.
Insured's Employer:	Insured's ID #:	Insured's Employer:	Insured's ID #:

Emergency Contact Information

His / Her Name:	Relation:	Mobile #: ( )	Home #: ( )
Address: CITY STATE ZIP			

4. MEDICAL INFORMATION

Do you have a personal physician? ☐ Yes ☐ No	Physician's Name:	Phone #: ( )	Date of last visit:
Are you currently under the care of a physician? ☐ Yes ☐ No	Please Explain:		

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5. MEDICAL / DENTAL HISTORY

Your current physical health is: ☐ Good ☐ Fair ☐ Poor	**Have you ever taken Fosamax, or any other bisphosphonate?** ☐ Yes ☐ No
Do you smoke or use tobacco in any other form? ☐ Yes ☐ No	Have you ever taken Fen-Phen? ☐ Yes ☐ No
Have you had any metal rods, pins or implants? ☐ Yes ☐ No	**Are you taking any prescription, over-the-counter or herbal supplemental drugs?** ☐ **Yes** ☐ **No**
Have you been told that you snore while sleeping or have you been diagnosed with sleep apnea? ☐ Yes ☐ No	Please list each one:

For Women:

Are you using a prescribed method of birth control? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No Week#: Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems? (Please Circle Y or N)

Y N Abnormal Bleeding	Y N Emphysema	Y N High Blood Pressure	Y N Rheumatic / Scarlet Fever
Y N Alcohol / Drug Abuse	Y N Epilepsy	Y N HIV+ / AIDS	Y N Seizures
Y N Anemia	Y N Fainting Spells	Y N Hospitalized for Any Reason	Y N Shingles
Y N Arthritis	Y N Frequent Headaches	Y N Kidney Problems	Y N Sickle Cell Disease / Traits
Y N Artificial Bones / Joints / Valves	Y N Glaucoma	Y N Liver Disease	Y N Sinus Problems
Y N Asthma	Y N Hay Fever	Y N Low Blood Pressure	Y N Sleep Apnea
Y N Blood Transfusion	Y N Heart Attack	Y N Lupus	Y N Stroke
Y N Cancer / Chemotherapy	Y N Heart Murmur	Y N Mitral Valve Prolapse	Y N Thyroid Problems
Y N Colitis	Y N Heart Surgery	Y N Osteoporosis / Paget's Disease	Y N Tuberculosis
Y N Congenital Heart Defect	Y N Hemophilia	Y N Pacemaker	Y N Ulcers
Y N Diabetes	Y N Hepatitis	Y N Psychiatric Problems	Y N Venereal Disease
Y N Difficulty Breathing	Y N Herpes / Fever Blisters	Y N Radiation Treatment	

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following? (Please Circle Y or N)

Y N Aspirin	Y N Dental Anesthetics	Y N Latex	Y N Tetracycline
Y N Codeine	Y N Erythromycin	Y N Penicillin	Y N Other

Please list any other drugs / materials that you are allergic to:

Why have you come to the dentist today?

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

Do you require antibiotics before dental treatment? ☐ Yes ☐ No	Do you like your smile? ☐ Yes ☐ No	Do your gums ever bleed? ☐ Y ☐ N
Are you currently in pain? ☐ Yes ☐ No	How many times a week do you floss?	a day do you brush?
Do you have fears about going to the dentist? ☐ Yes ☐ No	Type of bristles? ☐ Soft ☐ Medium ☐ Hard	
Have you ever had gum treatment? ☐ Yes ☐ No	How long do you use a toothbrush before replacing it?	
Your Current Health is ☐ Good ☐ Fair ☐ Poor	Are your teeth sensitive to heat, cold, or anything else?	
Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No	Have you lost any teeth? ☐ Yes ☐ No	If yes, why?

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information 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 any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature Date

6. FINANCIAL

Payment is due in full at the time of treatment unless prior arrangements have been approved.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my dental benefit / insurance plan does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefit otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature Date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY

Signature of Doctor / Reviewed By: Date:

Doctor's Comments: