

Patient Information

Name _____ Nick Name _____
 Last First MI

Address _____ Home# _____

City _____ State _____ Zip _____ Cell# _____

Age _____ DOB ____/____/____ Soc. Sec. # _____ - _____ - _____ Work# _____

E-mail: _____ Facebook User: Yes No Twitter User: Yes No

Male ____ Female ____ Marital Status: Single Married Divorced Widowed Child

Employer _____ Occupation _____

Whom may we thank for referring you? _____

In case of emergency who should we contact? _____ Phone # _____

How would you like to be notified of appointments? (circle all that apply) EMAIL TEXT PHONE

PRIMARY DENTAL INSURANCE INFORMATION

Subscriber (member) _____ Relationship to Patient _____

Subscriber DOB ____/____/____ Subscriber SS# _____ - _____ - _____

Subscriber Employer _____ Business Phone# _____

Insurance Co. _____ Group# _____ Ins. Phone# _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care: _____

Former Dentist _____ Date of last dental x-rays: _____

Have you ever or are currently having any problems with the following:

<input type="checkbox"/> Sensitivity to sweets	<input type="checkbox"/> Bite sensitivity	<input type="checkbox"/> Sores, Growths or Fever Blisters
<input type="checkbox"/> Clicking or popping jaw	<input type="checkbox"/> Sensitivity to hot/cold	<input type="checkbox"/> Grinding teeth
<input type="checkbox"/> Loose teeth/broke fillings	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Food Collection
<input type="checkbox"/> Missing Teeth	<input type="checkbox"/> Loose Dentures	<input type="checkbox"/> Bad Taste in Mouth

Current Pain Scale: (mark X) mild 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 severe

How often do you floss? _____ How often do you brush? _____

Are you happy with: Your smile _____ Color of teeth _____ Alignment of teeth _____

What would you change about your smile? _____

Do you use Nitrous Oxide (Laughing Gas)? (\$60 fee) Yes _____ No _____

MEDICAL HISTORY

Physician's Name _____ Phone Number _____

Date of last medical care _____ Reason _____

Have you ever taken any of the group of weight loss drugs collectively referred to as "fen-phen"? (Including combinations of Lonimin, Adipex, Fastin, Pondimin and Redux) Yes _____ No _____

Have you ever taken Fosamax, Boniva or other osteoporosis medication? Yes _____ No _____

Have you had any serious illnesses or operations? Yes _____ No _____ Date _____

Describe _____

Have you ever had a blood transfusion? Yes _____ No _____ Approximate dates _____

WOMEN: Pregnant? Yes ___ No ___ Due Date _____ Nursing? Yes ___ No ___ Birth control? Yes ___ No ___

Circle if you have ever had in the past or currently have any of the following:

Allergies	Diabetes	High Blood Pressure	Scarlet Fever
Anemia	Dizziness	HIV ___ Aids ___	Shortness of Breath
Arthritis	Epilepsy (Seizures)	Jaundice	Sinus Problems
Artificial Heart Valves	Epinephrine Reaction	Jaw Pain	Skin Rash
Artificial Joints	Excessive Bleeding	Kidney Disease	Stroke
Asthma	Fainting	Liver Disease	Stomach Problems
Back Problems	Glaucoma	Mental Disorders	Sulfa Drugs
Blood Disease	Growths	Mitral Valve Prolapse	Swelling of Feet/Ankles
Cancer	Hay Fever	Nervous Disorders	Thyroid Problems
Chemical Dependency	Headaches	Nervous due to Dentistry	Tobacco Habit
Chemotherapy	Head Injuries	Pacemaker	Tonsillitis
Circulatory Problems	Heart Disease	Penicillin Allergy	Tuberculosis
Codeine Allergy	Heart Murmur	Radiation Treatment	Tumors
Cortisone Treatments	Heart Problems	Respiratory Disease	Ulcer
Cough (Persistent)	Hemophilia	Rheumatic Fever	Venereal Disease
Coughing up blood	Hepatitis A B C	Rheumatism	Other:

Medications (list Medications you are currently taking with condition being treated)

Allergies:

Have you ever been advised to pre-medicate prior to a dental appointment? Yes No

Are you currently taking any blood thinners such as Aspirin, Plavix, Coumadin, etc? Yes No

Have you ever had an allergic reaction to LATEX? Yes No

AUTHORIZATION AND CONSENT FOR SERVICES

I acknowledge that I understand the Patient Privacy Notice and have been given a copy of my rights if requested. I authorize my insurance company (if applicable) to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I authorize the dentist to release all health information necessary to secure the payment for benefits. In addition, Reflections Dental Care may share my health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other healthcare personnel providing your treatment. I understand that I am financially responsible for all charges whether or not paid by my insurance. Additionally, I understand that I will be given an *estimate* for services due in advance of insurance payment. If insurance does not pay as much as expected, I understand that I am responsible for the remaining payment in a timely manner. I have made the doctor aware of all medical conditions and drug allergies past and present and realize that there are risks involved with dental procedures. I understand that it may be recommended for me to consent with my medical physician before proceeding with treatment due to past/present medical conditions. *I also understand that if I cancel without giving 48 hours notice or do not show up to my reserved appointment, I will be charged a minimum fee of \$35 up to 15% of my scheduled appointment fee.* **Payment is due in full at time of treatment unless prior arrangements have been approved.**

_____ Date _____

Print Patient Name

Patient or Legal Guardian Signature