Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. _____
Last Name First Name Initial

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Email _____

Preferred contact method: Phone ☐ Cell ☐ or Home ☐ Text ☐ Email ☐

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married

Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

Notify in case of emergency _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. _____

Address (If different from patient) _____ Phone _____

City _____ State _____ Zip _____

Cell _____ Email _____ Preferred Contact _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contact # _____ Group # _____ Subscriber $ _____

Name of other dependents under this plan _____

Dental History

Are you in dental discomfort today? _____

Date of Last Dental Checkup _____ Date of Last X-rays _____

Check (✓) if you have had problems with any of the following:

☐ Bad breath ☐ Food collection between teeth ☐ Periodontal treatments ☐ Sensitivity to sweets
☐ Bleeding gums ☐ Grinding or clenching teeth ☐ Sensitivity to cold ☐ Sensitivity when biting
☐ Clicking or popping jaw ☐ Loose teeth or broken fillings ☐ Sensitivity to hot ☐ Sores or growths in mouth
☐ Do you snore?

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

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? _____

Other information about your dental health or previous treatment _____

_____

How do you feel about the appearance of your teeth? _____

Dr. Parker or Dr. McDaniel

Would you be interested in talking with Dr Parker or McDaniel about the following:

☐ Teeth Whitening ☐ Changing silver fillings to white ☐ Veneers

☐ Invisalign: (invisible braces) ☐ Vivera: invisible removable retainers. They can even replace your old metal bar.

Medical History

Physician's name _____ Address _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have had any of the following:

☐ AIDS
☐ Anaphylaxis
☐ Anemia
☐ Arthritis, Rheumatism
☐ Artificial heart valves
☐ Artificial joints
☐ Aspirin Daily
☐ Asthma
☐ Atopic (allergy prone)
☐ Blood disease
☐ Blood thinners
☐ Cancer
☐ Chemical dependency
☐ Chemotherapy
☐ Circulatory problems
☐ Cortisone treatments
☐ Cough, persistent
☐ Diabetes
☐ epilepsy
☐ Fainting
☐ Food allergies
☐ Glaucoma
☐ Headaches
☐ Heart murmur
☐ Heart problems
Describe _____
_____
☐ Hemophilia
☐ Herpes
☐ Hepatitis
☐ High blood pressure
☐ HIV positive
☐ Jaw pain
☐ Kidney disease or malfunction
☐ Mitral valve prolapse
☐ Nervous problems
☐ Pacemaker
☐ Rapid weight gain or loss
☐ Radiation treatment
☐ Respiratory disease
☐ Rheumatic fever
☐ Scarlet fever
☐ Shortness of breath
☐ Skin rash
☐ Stroke
☐ Surgical implant
☐ Swelling of feet or ankles
☐ Thyroid disease or malfunction
☐ Tobacco habit
☐ Tonsillitis
☐ Tuberculosis
☐ Ulcer
☐ Venereal disease

List medications you are currently taking, if any

_____

_____

List drug allergies, if any

_____

_____

Authorization

I have reviewed the information on the questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions

I authorize the dentist to release all information necessary to secure the payment or benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

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