

Welcome to Advantage Dental Center

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

First Name _____ Last _____ MI _____ Soc. Sec. _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex: M F Age _____ Birthday _____ Single Married Widowed Separated Divorced

Patient employed by _____ Occupation _____

Business Address _____

Business Email _____ Business Phone _____

Who may we thank for referring you?

Notify in case of emergency _____ Contact Phone _____

Primary Insurance

Person responsible for account _____

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Person responsible employed by _____ Occupation _____

Business Address _____

Business Email _____ Business Phone _____

Insurance Company _____ Phone _____

Insurance Email _____

Contact # _____ Group # _____ Subscriber's # _____

Name(s) of other dependents under this plan _____

Additional Insurance

Is the patient covered by additional insurance? Y N

Subscriber's Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber employed by _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contact # _____ Group # _____ Subscriber's # _____

Name(s) of other dependents under this plan _____

Dental History

What would you like us to do today? _____

Are you in dental discomfort today? _____

Former Dentist _____ Address _____ Phone _____

Dentist's Email address _____

Date of last dental care _____ Date of last Dental X-rays _____

Check Y for yes and N for No if you have or have not had the following:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Bad Breath | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets | <input type="checkbox"/> Y <input type="checkbox"/> N Cold Sensitivity | <input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth or broken fillings |
| <input type="checkbox"/> Y <input type="checkbox"/> N Food collection between teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding gums | <input type="checkbox"/> Y <input type="checkbox"/> N Biting Sensitivity | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to hot |
| <input type="checkbox"/> Y <input type="checkbox"/> N Periodontal treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Grinding or Clenching | <input type="checkbox"/> Y <input type="checkbox"/> N Clicking or popping Jaw | <input type="checkbox"/> Y <input type="checkbox"/> N Sores or growths in mouth |

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

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

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

Medical History

Physician's Name _____ Address _____ Phone _____

Physician's Email _____

Date of last visit _____ Have you ever had any serious illnesses or operations? Y N If Yes, Describe _____

Are you currently under physician care? Y N If yes, describe _____

Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Check Y for Yes and N for no if you have or have not had the following:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive | <input type="checkbox"/> Y <input type="checkbox"/> N Persistent cough | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease | <input type="checkbox"/> Y <input type="checkbox"/> N Skin rash |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis | <input type="checkbox"/> Y <input type="checkbox"/> N Cough up blood | <input type="checkbox"/> Y <input type="checkbox"/> N Liver disease | <input type="checkbox"/> Y <input type="checkbox"/> N Spina bifida |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Latex allergy | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse | <input type="checkbox"/> Y <input type="checkbox"/> N Surgical implant |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting | <input type="checkbox"/> Y <input type="checkbox"/> N Nervous problems | <input type="checkbox"/> Y <input type="checkbox"/> N Swelling of feet and ankles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial joints, Where: _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Food allergies | <input type="checkbox"/> Y <input type="checkbox"/> N Osteoporosis | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker/Heart Surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Tobacco use |
| <input type="checkbox"/> Y <input type="checkbox"/> N Back problems | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric care | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood disease | <input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/Colitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer, Type: _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Heart problems | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemical dependency | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic fever | <input type="checkbox"/> Y <input type="checkbox"/> N Other _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N Scarlet fever | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Circulatory problems | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cortisone treatments | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath | |

List medications you are currently taking: _____

List of any drug allergies: _____

Authorization

I have reviewed the information on this 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 helpful dental treatment. If there is any change in medical status, I will inform the dentist.

I authorize my insurance company to pay 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 of benefits. I understand that I am financially responsible for all charges not paid by insurance and that payment in full (Patient portion) is due at the time of treatment.

I authorize Advantage Dental Center to discuss treatment, payment, and health related information that pertains to my treatment with the following people:

Please List: _____

Signature _____ Date _____