Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Address: _____
Street Apartment #

_____
City State Zip Code

Gender: _____ Family Status: _____Spouses/Partners Name:_____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell _____

Best time to call: _____Email:_____ May we contact you via text? ☐Yes ☐No
Emergency Contact Name :_____ Phone: _____ Relationship:_____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____
Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____ « »
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Secondary Insurance

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Medical Health History

Information that you feel insignificant could be directly related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all questions in detail.

Name of Physician: _____ Phone: _____
Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____

Do you have or have you been treated for any of the following? Please check those that apply:

☐ Any Heart Problems
☐ Heart Attack
☐ Angina
☐ ByPass
☐ Pacemaker
☐ Stroke
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Heart Murmur
☐ Mitral Valve Prolapse
☐ Heart Valve Defect
☐ Heart Valve Replacement
☐ Rheumatic Fever
☐ Artificial Joint (hip/knee)
☐ Bleeding Disorders
☐ Anemia
☐ Hemophilia
☐ Sickle Cell Trait
☐ Blood Transfusions
☐ Lung/Breathing Problems
☐ Asthma

☐ Bronchitis
☐ Migraines
☐ Emphysema
☐ Tuberculosis
☐ Sinus Trouble
☐ Diabetes
☐ Difficulty in Healing
☐ Liver Problems/Dysfunction
☐ Hepatitis/Jaundice
☐ Kidney Problems
☐ Tobacco use
☐ Alcoholism
☐ Drug Abuse
☐ Nervous or Mental Disorder
☐ Thyroid Problems
☐ Adrenal/Pituitary Problems
☐ Sexually Transmitted Diseases
☐ Epilepsy or Seizures
☐ Other infectious Diseases

☐ HIV/AIDS
☐ Cancer/Tumors
☐ Other Growths
☐ Chemotherapy/Radiation
☐ Rheumatic Fever
☐ Rheumatism
☐ Seizures
☐ HPV
☐ Stomach Problems
☐ Stroke
☐ Ulcers

Allergies

☐ Codeine Allergy
☐ Penicillin Allergy
☐ Erythromycin Allergy
☐ Sulfa Allergy
☐ Aspirin Allergy
☐ Local Anesthetic Allergy
☐ Latex Allergy
☐ Allergies _____
_____

OTHER:
☐ _____

☐ Smoker? If yes how many a day_____ How long have you smoked?____
☐ Taking Medications?
List _____
_____
_____
_____
Natural/Herbal Supplements:_____
_____
_____
_____

☐ Pregnancy
Due date:_____

- Do you take antibiotic pre-medication prior to dental appointments? ☐ Yes ☐ No

- Have you been admitted to a hospital or needed emergency care during the past five years? ☐ Yes ☐ No
  If yes, please explain: _____

- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Dental History

Reason for this visit: _____

Name and address of last
dentist:_____
Date of last dental visit _____
Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain:

_____

How often do you brush your

teeth?_____Floss?_____

What texture brush do you use? Soft ☐ Medium ☐ Hard ☐ Nylon ☐ Natural ☐

Do your gums bleed while brushing? ☐ Yes ☐ No Do your gums bleed when flossing? ☐ Yes ☐ No

Do you avoid brushing or flossing any part of your mouth because of pain or swelling? ☐ Yes ☐ No

If yes, where? _____

Do you feel pain when your teeth come in contact with:

- Hot foods or liquids, i.e., soup, coffee, tea, etc.? ☐ Yes ☐ No
- Cold foods or liquids, i.e., ice cream cold fruit etc.? ☐ Yes ☐ No
- Sweets, i.e., candy, fruit, sweet desserts, etc.? ☐ Yes ☐ No
- Sours, i.e., Lemons, limes, grapefruit, etc.? ☐ Yes ☐ No

Do you chew on only one side of your mouth? ☐ Yes ☐ No

If yes explain

_____

Do you clench or grind your teeth while sleeping or during the day? ☐ Yes ☐ No
Does your jaw ever feel tired? ☐ Yes ☐ No
Do you wear removable dentures or partials? ☐ Yes ☐ No
Do you usually have many cavities? ☐ Yes ☐ No
Do you lose fillings or break fillings? ☐ Yes ☐ No
Do you gag easily? ☐ Yes ☐ No
Are you familiar with the term “Preventive Dentistry”? ☐ Yes ☐ No
Have you ever thought about whitening your teeth? ☐ Yes ☐ No
Do you like the position, angle and shape of your teeth? ☐ Yes ☐ No
Have you ever thought about changing your smile? ☐ Yes ☐ No
Do you snore? ☐ Yes ☐ No
If you snore does it affect your sleeping partner? ☐ Yes ☐ No
Do you wake up tired or not rested in the morning? ☐ Yes ☐ No

Please add anything you feel is important

_____

_____

_____

_____

_____

_____

Patient Treatment Consent

I certify that I have read and understand the above information, including privacy notice and have accurately completed the forms. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satifaction. I will not hold my dentist, or other members of his/her staff, responsible for any errors or ommissions that I may have made in the completion of this form.

I authorize the Greene Dental Group or designated staff treating me to perform such diagnostic aids deemed appropriate to make a through diagnosis of my dental needs. Upon such diagnosis, I authorize the dentist/staff to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the dentist and mutually agreed upon by me.

I understand that the use of any photos, models or other images taken by either the dentist or designated staff may be used for diagnostic, educational or marketing purposes. My identity will be held confidential.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed. A service charge of 1½% per month (18% per annum) on unpaid balances will be charged on all accounts exceeding 60 days. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. I further agree to pay any collection costs including but not limited to reasonable attorney's fees, court and / or collection costs which may arise from non-payment of my account.

I give my consent for my dependents to have treatment as deemed necessary if I am absent from dependent's appointment. I also agree that anyone I have chosen to bring my dependent to the dentist has my permission to consent to whatever treatment is deemed necessary. I agree to be responsible for payment of all services on behalf of my dependents.I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the dentist. I understand that treatment recommendations are based on the needs of the patient, not my insurance company. I understand while the dental practice will assist me in processing my insurance claims, I am responsible for all fees for services rendered. This form also authorizes their practice to submit insurance claim forms and receive payment directly from insurance carrier with notation "SIGNATURE ON FILE" I authorize my dentist(s) to release treatment records/x-rays or any other information deemed pertinent to my insurance carrier as necessary and or requested.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party