Welcomes You!

Thank you for selecting our dental health care team! We strive to provide you with the best possible dental care. To help us meet all your dental health care needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us, we will be happy to help.

PATIENT INFORMATION

Name ______ Birthdate ______ SS# ______ Date ______

If Child, Parents or Guardians ______ ❒ Minor ❒ Single ❒ Married ❒ Other

Home Address ______ City ______ State ______ Zip ______

Home Telephone ______ Patient's or Parent's Employer ______ Occupation ______

Work Telephone ______ Ext. ______ Pager/Other ______ How Long Employed? ______

Business Address ______ City ______ State ______ Zip ______

E-mail Address ______ Drivers License # ______

Emergency Contact: ______ Phone: ______

PLEASE CIRCLE: SPOUSE / PARENT INFORMATION

Their Name ______

Employer ______

Work Telephone ______ Ext. ______

Birth Date ______ SS# ______

HOW DID YOU FIND OUT ABOUT US?

Whom may we thank for referring you to Southridge Dental ______

What other ways have you heard about us?

❒ Sign/Location ❒ Radio
❒ Telephone Directory ❒ Coupons
❒ Internet/Web Site ❒ Business Cards
❒ Idaho Press Tribune

DENTAL INSURANCE

Primary Dental Insurance

Insurance Company Name ______

Insurance Co. Address ______

Insurance Co. Telephone ______

Group Number ______ Policy I.D.# ______

Insured's Name ______

SS# ______ D.O.B. ______

How much is your Deductible? ______

Secondary Dental Insurance

Insurance Company Name ______

Insurance Co. Address ______

Insurance Co. Telephone ______

Group Number ______ Policy I.D.# ______

Insured's Name ______

SS# ______ D.O.B. ______

How much is your Deductible? ______

MEDICAL HISTORY

Name of Physician ______

Telephone ______ Date of Last Visit ______

Are you under medical treatment now? ❒ Yes ❒ No

Your current health is: ❒ Good ❒ Fair ❒ Poor

Are you taking any prescription drugs? ❒ Yes ❒ No

Are you taking any non-prescription medications? ❒ Yes ❒ No

DENTAL HISTORY

How may we help today? ______

Are you currently in pain? ______

Your current dental health is: ❒ Good ❒ Fair ❒ Poor

Are you allergic to or have you had a reaction to any of the following?

Y	N	Penicillin/Antibiotics	Y	N	Dental Anesthetics
Y	N	Aspirin	Y	N	Codeine
Y	N	Erythromycin	Y	N	Latex
Y	N	Tetracycline	Y	N	Sulfa Drugs
Y	N	Iodine	Y	N	Metals (Mercury)

How do you feel about the appearance of your teeth? ______________ Would you be interested in bleaching? ______________

Previous dentist ______________ Location ______________

Date of last dental care ______________ Last dental x-rays ______________

Please check(✓) if you have had trouble with any of the following:

❒ Bad Breath	❒ Grinding Teeth	❒ Sensitivity to Heat
❒ Bleeding Gums	❒ Loose Teeth or Broken Fillings	❒ Sensitivity to Sweets
❒ Clicking or Popping Jaw	❒ Periodontal Treatment	❒ Sensitivity when Biting
❒ Food collection between teeth	❒ Sensitivity to Cold	❒ Sores or growths in your mouth

How often do you floss? ______________ How often do you brush? ______________

Have you ever experienced an adverse reaction during or in conjunction with a dental procedure? If yes, explain ______________

Previous hospitalizations, illnesses, or operations (please describe, and give approximate date) ______________

____

Have you ever had a blood transfusion? ❒ Yes ❒ No If yes, please give approximate date ______________

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

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

❒ AIDS	❒ Cortisone Treatments	❒ Hepatitis	❒ Rheumatic Fever
❒ Anemia	❒ Cough, Persistent	❒ High Blood Pressure	❒ Scarlet Fever
❒ Arthritis, Rheumatism	❒ Cough up Blood	❒ HIV Positive	❒ Shortness of Breath
❒ Artificial Heart Valves	❒ Diabetes	❒ Jaw Pain	❒ Skin Rash
❒ Artificial Joints	❒ Epilepsy	❒ Kidney Disease	❒ Stroke
❒ Asthma	❒ Fainting	❒ Liver Disease	❒ Swelling of Feet or Ankles
❒ Back Problems	❒ Glaucoma	❒ Mitral Valve Prolapse	❒ Thyroid Problems
❒ Blood Disease	❒ Headaches	❒ Nervous Problems	❒ Tobacco Habit
❒ Cancer	❒ Heart Murmur	❒ Pacemaker	❒ Tonsillitis
❒ Chemical Dependency	❒ Heart Problems	❒ Psychiatric Care	❒ Tuberculosis
❒ Chemotherapy	Describe__________	❒ Radiation Treatment	❒ Ulcer
❒ Circulatory Problems	❒ Hemophilia	❒ Respiratory Disease	❒ Venereal Disease

Please list any medications, both prescription and non-prescription, you are currently taking ______________

Please list any allergies ______________

Signature ______________ Date __________ Signature ______________ Date __________

Signature ______________ Date __________ Signature ______________ Date __________

Signature ______________ Date __________ Signature ______________ Date __________

I have reviewed this questionnaire and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment, and I agree to notify the dentist if any change in my health status should occur.

I authorize the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize use of this signature on all insurance submissions.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf. I understand that payment is due on the day of service unless other arrangements have been made. Any balance on account after 90 days will be assessed interest. The interest rate is 1.75% per month or 21% annually. I realize that failure to keep this account current may result in you being unable to provide additional services except for emergencies or prepayment of services. In the case of default on payment of this account, I agree to pay all collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any further outstanding account balances.

Signature ______________ Date ______________