Patient Information Form

FOR OFFICE USE ONLY

Doctor #_____
Patient #_____
_____

Downtown DENTAL ASSOCIATES
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Last Name_____ First Name_____ Initial_____ Date_____
Address_____ City_____ State_____ Zip_____
Home Phone_____ Work Phone_____ Cell Phone_____ Email_____
SSN_____ Birth Date_____
Check boxes that apply to you: ☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Patient's (or Parent's) Employer_____ Dept._____ Phone/Ext._____ Years of Employment____
Spouse (or Parent's) Name_____ Employer_____ Work Phone_____
If you are a student, name of School/College_____ City_____ State_____
In case of emergency, we should call_____ Phone_____ Relation to Patient_____
Which Doctor do you wish to see_____ How did you come to be our patient_____

Financial Information

Name of person responsible for paying this account_____ Relationship to you_____
Address_____ City_____ State_____ Zip_____ Phone_____
Social Security Number_____ Birth Date_____
Employer_____ Phone_____ Is this person a current patient of ours? ☐ Yes ☐ No
We offer the following ways to pay your bill in full at each appointment. Check your preference: ☐ Cash ☐ Check ☐ Credit Card

Dental Insurance Information

Primary Insurance Company_____ Group #_____ Employee/Certificate #_____
Insurance Company Address_____ City_____ State_____ Zip_____
Insured Person_____ Relationship to you_____ Insured's Birth Date_____
Insured's Employer_____ Phone_____ Insured's SSN_____

Dental History

Date of last dental visit_____ Purpose of today's visit_____

1. Do your gums bleed when you brush or floss? ☐ Yes ☐ No
2. Are your teeth sensitive to hot or cold foods or liquids? ☐ Yes ☐ No
3. Are your teeth sensitive to sweet or sour foods or liquids? ☐ Yes ☐ No
4. Do you feel pain in any of your teeth? ☐ Yes ☐ No
5. Do you have any sores or lumps in or near your mouth? ☐ Yes ☐ No
6. Have you had any head, neck or jaw injuries? ☐ Yes ☐ No
7. Have you ever had any of the following problems with your jaw?
   - Clicking ☐ Yes ☐ No
   - Pain in joint, ear or side of face ☐ Yes ☐ No
   - Difficulty in opening or closing ☐ Yes ☐ No
   - Difficulty in chewing ☐ Yes ☐ No
8. Do you have frequent headaches? ☐ Yes ☐ No
9. Do you clench or grind your teeth? ☐ Yes ☐ No
10. Have you had any difficult extractions? ☐ Yes ☐ No
11. Have you had any orthodontic work? ☐ Yes ☐ No
12. Have you had prolonged bleeding after an extraction? ☐ Yes ☐ No
13. Have you been taught how to brush your teeth correctly? ☐ Yes ☐ No
14. Have you ever been advised on how to care for your gums? ☐ Yes ☐ No

Medical History

Physician _____ Office Phone _____

Date of last exam _____

1. Are you under medical treatment? ☐ Yes ☐ No

2. Have you ever been hospitalized for surgery or serious illness?
   ☐ Yes, for: _____
   _____ ☐ No

3. Are you taking any medications?
   ☐ Yes, which medicines _____
   _____
   _____
   _____ ☐ No

4. Do you use tobacco products? ☐ Yes ☐ No

5. Are you allergic to or have any reactions to the following?

Local anesthetics like Novocain	☐ Yes	☐ No
Penicillin	☐ Yes	☐ No
Erythromycin	☐ Yes	☐ No
Codeine	☐ Yes	☐ No
Aspirin	☐ Yes	☐ No
Any others not listed	☐ Yes	☐ No

   Please specify: _____

6. For female patients:

Are you pregnant or think you may be?	☐ Yes	☐ No
Are you taking birth control pills?	☐ Yes	☐ No

7. Do you have or have you had any of the following?

High blood pressure	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No
Rheumatic fever	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Leukemia	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Low blood pressure	☐ Yes	☐ No
Epilepsy or convulsions	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No
Cardiac pacemaker	☐ Yes	☐ No
Kidney diseases	☐ Yes	☐ No
AIDS or HIV infection	☐ Yes	☐ No
Thyroid problem	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No
Angina	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Stomach troubles or ulcers	☐ Yes	☐ No
Hepatitis or Jaundice	☐ Yes	☐ No
Sexually transmitted disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Joint replacement or implant	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Hay fever or other allergies	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Radiation therapy	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Liver disease	☐ Yes	☐ No
Heart trouble	☐ Yes	☐ No
Respiratory problems	☐ Yes	☐ No
Anything else	☐ Yes	☐ No

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_____

Authorization and Release

We will be glad to file your Insurance Claims at no charge, but any disputes on claims are between you and your insurer.

I authorize Downtown Dental Associates to release any information including the diagnosis and the records of any treatment or examines rendered to me or my child during the period of such dental care to third party payers and/or other heath practitioners.
I authorize and request my insurance company to pay directly to the dentist or dental group any insurance benefits otherwise payable to.
I understand that my dental insurance carrier may pay an amount less than the actual bill for services.
I agree to be held responsible for payment of all services rendered on behalf of me or my dependents.
I certify that I have read and understood the information on this form. I have answered all questions truthfully to the best of my knowledge.
I understand that providing incorrect information can be detrimental to my health.
I understand that in the event I do not pay my bill that is owed to Downtown Dental Associates I agree and will pay and all reasonable collection and/or attorney's fees involved in the recovery of monies due to Downtown Dental Associates.

I acknowledge Patients Rights and Privacy Practice Act has been made available to me.

Signature of patient, parent or guardian: _____ Date _____