Shelton DENTAL CENTER

Welcome To Our Practice

Patient Information

Today's Date____________

Name____

Last First Middle Initial Nickname

Married Single Other Male Female Birth date____________ Age_______

Address____

City______________________________ State____________ Zip Code_________________

Phone(home)______________ Phone(cell)______________ Phone(work)______________

E-mail address__________________________ May we contact you at work? ◇ yes ◇no

Social Security #_____________________ Occupation______________________________

Employer Name____

Employer Address____

Emergency Contact/Spouse's Name__________________________ Birth date__________

Phone(home)______________ Phone(cell)______________ Phone(work)______________

Spouse's Employer____

Employer Address____

Whom may we thank for referring you to us?_____________________________________

Primary Dental Insurance

Subscriber Name_____________________ Social Security #_____________ DOB_______

Employer Name and Address____

Insurance Co. Name and Address____

____ Insurance Co. Phone________________

Group #_______________________ Policy/Subscriber ID#__________________________

Relationship to Patient____

Secondary Dental Insurance

Subscriber Name_____________________ Social Security #_____________ DOB_______

Employer Name and Address____

Insurance Co. Name and Address____

____ Insurance Co. Phone________________

Group #_______________________ Policy/Subscriber ID#__________________________

Relationship to Patient____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance carriers and assign directly to Shelton Dental Center all insurance benefits, if any, otherwise payable directly to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize my dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. The information on this page and the medical history are correct to the best of my knowledge.

Responsible Party________________________________ Relation to patient______________

Signature____ Date__________________

Dental History

Why have you come to the dentist today?____

Are you currently in Pain? yes no Current Dental Health? Good Fair Poor

Do you require antibiotics prior to dental treatment? yes no unsure

Have you ever had a difficult or serious problem with previous dental work? yes no

Do you have a fear of the dentist? none mild moderate severe

Why did you leave your last dentist?____

What did you like most about your last dentist?_____________________________________

Do you love your smile? yes no What would you like to change?___________________

Do your gums ever bleed? yes no Have you ever had periodontal disease? yes no

How many times a week do you floss?______ How many times a day do you brush?______

Medical History

Have you ever had any of the following diseases or medical problems?

Please check all that apply.

Conditions:

- Abnormal bleeding
- Alcohol or Drug Abuse
- Aids/HIV
- Allergies
- Anemia
- Angina
- Asthma
- Blood transfusions
- Cancer/chemotherapy
- Diabetes
- Difficulty Breathing
- Emphysema
- Epilepsy
- Fever Blisters/Herpes
- Heart Attack: Date______________
- Heart Murmur/Defect
- Heart Surgery
- Hemophilia/bleeding
- Hepatitis: Type___
- Blood Pressure: high low

Medical History Continued

Joint Replacement:
Date______________
Kidney Problems
Liver Disease
Pacemaker
Psychiatric Disease
Radiation therapy
Rheumatic Fever
Seizures
Sexually Trans Disease
Shingles
Sickle Cell Disease
Sinus Problems

Stroke
Thyroid problems
Tuberculosis
Ulcers
Other_______________

Allergies to:

Aspirin
Codeine
Anesthetics
Latex
Metals/Jewelry/Nickel
Penicillin
Sulfa
Tetracycline
Other______________

Miscellaneous:

Do you smoke? yes no
Do you chew? yes no

If Female:

Are you taking Birth Control Pills? yes no
Are you Pregnant? yes no

Current Medications and dosage:____
____

Physician Information:

Name of Current Physician__________________________________ Phone_________________
Name of Specialist Physician________________________________ Phone_________________

OFFICE USE ONLY: Updates

1. Date_________ Comments____________________________ Signature_______________
2. Date_________ Comments____________________________ Signature________________