MAIN STREET DENTAL

A Redefined Dental Experience.

ABOUT YOU

Who Can We Thank For Referring You: _____

Patient Name: _____

What You Prefer To Be Called: _____ Male Female

Birthdate: _____/_____/_____ Age: _____ SS#: _____

Mailing Address: _____
Street *City* *State* *Zip*

Home Phone: (_____)_____ Work Phone: (_____)_____

Cell Phone: (_____)_____ Email Address: _____

Employer/Occupation: _____ How Long? _____

Employer Address: _____

Marital Status: _____ Spouse's Name: _____

Do You Have Children? _____ How Many? _____

INSURANCE INFO

Primary Insurance Name: _____

Address: _____ Phone: (_____)_____

Insured's ID#: _____ Group# (Plan, Local, or Policy #): _____

Insured's Name: _____ Relation: _____

Date of Birth: _____/_____/_____ SS#: _____

Insured's Employer: _____

Secondary Insurance Name: _____

Address: _____ Phone: (_____)_____

Insured's ID#: _____ Group# (Plan, Local, or Policy #): _____

Insured's Name: _____ Relation: _____

Date of Birth: _____/_____/_____ SS#: _____

Insured's Employer: _____

ACCOUNT INFO

Person ultimately responsible for account

Name: _____ Relation: _____

Billing Address: _____

SS#: _____ Driver's License #: _____

Cell Phone: (_____)_____ Work Phone: (_____)_____

EMERGENCY CONTACT

Whom should we contact? _____

Relation: _____ Phone: (_____)_____

DENTAL INFO

Reason for today's visit: Exam Emergency Consultation

Are you in pain? No Yes How long? _____

Please indicate any of the following problems:

- Discomfort
- Broken or chipped tooth
- Sensitive tooth or gums
- Active decay or cavity
- Clicking or popping in jaw
- Teeth grinding
- Red, swollen, or bleeding gums
- Lost or broken filling
- Blisters or sores in or around mouth
- Ringing in ears
- Other: _____

Stained teeth

Locking jaw

Bad breath

Do You Require Pre-medication? Yes No Don't Know

Have you ever been treated for gum disease? Yes No

Previous Dentist: _____ Phone: _____

Address: _____

Last Dental Exam: _____ Last Dental X-rays: _____ Last Cleaning: _____

Have you had problems with previous dental treatment? _____

Times a day you brush? _____ Times a week you floss? _____

Type of toothbrush bristles? _____ Rate your smile from 1-10 (10 = Excellent): _____

Would you like whiter teeth?: _____ Have you had orthodontic treatment?: _____

Things you would change about your smile: _____

MEDICAL HISTORY & INFORMATION

What medications are you taking?

- Nerve pills
- Pain killers
- Muscle relaxers
- Stimulants
- Blood thinners
- Tranquilizers
- Insulin
- Meds for Osteoporosis
- Vitamins or supplements
- Others: _____

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) Phen-fen/Redux

Do you have or have you had any of the following diseases, medical conditions or procedures?

- Heart problems
- Lung disease
- Liver problem
- Blood disease
- Kidney problems
- Scarlet fever
- Tuberculosis
- HIV+AIDS/ ARC
- Rheumatic fever
- Sinus problems
- Heart attack or stroke
- Thyroid problems
- Seizures or epilepsy
- Venereal disease
- Cosmetic surgery
- Dizziness or fainting
- Cold/fever blisters
- Blood transfusion
- Alcohol/ drug abuse
- Eating disorder
- Heart surgery/ pacemaker
- Congenital heart defect
- Artificial heart valve
- Mitral valve prolapse
- G.I. problems
- Emphysema or asthma
- Diabetes
- Psychiatric problems

- Back/neck problems
- Respiratory problems
- Heart disease
- Cancer/tumor
- Chemotherapy/ radiation
- Frequent thirst/urination
- Bleeding problems
- Blood pressure problems
- Jaw problems
- Shingles
- Hepatitis
- Glaucoma
- Arthritis
- Chest pains
- Allergies
- Sleep problems
- Other surgeries or conditions: _____

Are you allergic to any of the following?

- Latex
- Penicillin/ Amoxicillin
- Tetracycline
- Aspirin
- Codeine
- Dental Anesthetics
- Other: _____

Do you use tobacco? _____ How much? _____ For how long? _____

Please rate your general health from 1-10: _____ Do you wear contact lenses? _____

For women: Are you taking birth control pills? _____ Hormonal replacement? _____

Are you pregnant? _____ How far along? _____ Are you nursing? _____

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

I acknowledge that I have received a copy of the Summary of Privacy Notice

Signature_____

Date