**1** **Today's Date:** ______________

**2** **Referred by:** ______________________

# 3 ABOUT YOU

First Name ______ Last Name ______ MI ______

Are you ALLERGIC to any of the following:

☐ Latex ☐ Penicillin/Amoxicillin ☐ Tetracycline ☐ Aspirin ☐ Dental Anesthetics

☐ Other: ______________________

Sex: ☐ Male ☐ Female Relationship Status: ☐ Married ☐ Single ☐ Divorced ☐ Other

What do you want to be called? ______ Social Security # ______ Birthdate ______ Spouse's Name (if applicable) ______

Address ______ City ______ Zip ______

Home Number ______ Cell Number ______ Work Number ______

Email Address ______

Employer ______ Occupation ______

Primary Physician ______ Physician Phone ______

Emergency Contact Name ______ Emergency Contact Home Phone ______ Cell Phone ______

# 4 ACCOUNT & INSURANCE INFORMATION

Policyholder ______ Relationship to Patient ______ Social Security # ______ DOB ______

Billing Address ______ City ______ State ______ Zip ______

Name of Insurance ______ Insurance ID# ______ Group Number ______

______ **Please Initial** *I, the person responsible for this account, hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I full comprehend I am the person solely responsible for any balance that is not paid by my insurance company.*

## SECONDARY DENTAL INSURANCE (if applicable)

Policyholder ______ Relationship to Patient ______ Social Security # ______ DOB ______

Billing Address ______ City ______ State ______ Zip ______

Name of Insurance ______ Insurance ID# ______ Group Number ______

# 5 PATIENT DENTAL INFORMATION

*Please indicate any for the following issues:*

- ☐ Discomfort, clicking or popping jaws
- ☐ Red, swollen or bleeding gums
- ☐ Sensitive tooth, teeth or gums
- ☐ Blisters/Sores in or around the mouth
- ☐ Lost/Broken filling(s)
- ☐ Teeth grinding
- ☐ Ringing in ears
- ☐ Broken/Chipped tooth
- ☐ Stained teeth
- ☐ Locking jaw
- ☐ Bad breath
- ☐ Other______________________

Previous Dentist ______________________ Last Dental Exam ______________ Last Dental X-Rays ______________

Have you ever had periodontal (gum) treatments? ☐ Yes ☐ No

Have you ever had a deep cleaning? ☐ Yes ☐ No

# 6 PATIENT MEDICAL HISTORY

Do you require pre-medication? ☐ Yes ☐ No ☐ Don't know

Please list any prescriptions or medications you are currently taking:

______________________________________________

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) ☐ Yes ☐ No Phen-fen/Redux: ☐ Yes ☐ No

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

- ☐ Heart attack/stroke
- ☐ Heart surgery/pacemaker
- ☐ Heart murmur
- ☐ Rheumatic fever
- ☐ Mitral valve prolapse
- ☐ Artifical valves
- ☐ Heart disease
- ☐ Congenital heart defect
- ☐ Chest pains
- ☐ Scarlet fever
- ☐ Nervousness
- ☐ Cosmetic surgery
- ☐ Xray or Cobalt treatment
- ☐ Chemotherapy
- ☐ Asthma
- ☐ Thyroid problems
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Respiratory problems
- ☐ Sinus problems
- ☐ Stomach problems/ulcers
- ☐ Psychiatric problems
- ☐ Venereal disease
- ☐ Alcohol/drug abuse
- ☐ Tuberculosis (TB)
- ☐ Jaw problems (TMJ/TMD)
- ☐ Difficulty breathing
- ☐ Diabetes/hypoglycemia
- ☐ Leukemia
- ☐ Anemia
- ☐ Cancer/tumors ____________
- ☐ Shingles
- ☐ Hepatitis____________
- ☐ HIV+/AIDS/ARC
- ☐ Arthritis/rheumatism
- ☐ Artificial bones/joints
- ☐ Emphysema
- ☐ Fainting/seizures/epilepsy
- ☐ Severe/frequent headaches
- ☐ Frequent neck pain
- ☐ Back problems
- ☐ High/low blood pressure
- ☐ Bleeding problems
- ☐ Glaucoma

Do you use tobacco? ☐ No ☐ Yes/How used?____________ How much?____________ How long?________

*For women:*

Do you take birth control pills? ☐ No ☐ Yes Are you pregnant? ☐ No ☐ Yes

# 7 PATIENT CONSENT FOR SERVICES

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 Dr. Palm and his staff at my next appointment.

I have had full opportunity to read and consider the contents of this form AND the Notice of Privacy practices. I authorize staff to perform any necessary services needed during diagnosis and treatment.

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

I will not hold Palm Family Dental responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

**SIGNATURE REQUIRED** ______________________ **DATE** ____________