Scott Family Dentistry

Date _____ **Patient Name** _____ **Name you wish to be called** _____
Physical Address _____ **Home Phone** _____
City _____ **State** _____ **Zip Code** _____ **Work Phone** _____
Mailing Address _____ **Cell Phone** _____
City _____ **State** _____ **Zip Code** _____
Best Time and Place to Reach You Live and In Person _____
Sex: ☐ **M F** ☐ **Age** _____ **Birthdate** _____ ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Separated** ☐ **Divorced**
Patient SS # _____ **Occupation** _____ **Employer** _____
Employer Address _____ **Employer Phone** _____
Spouse Name _____ **Birthdate** _____ **SS#** _____
Occupation _____ **Spouse's Employer** _____

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IN CASE OF EMERGENCY PLEASE CONTACT (someone not living with you)
Name _____ **Relationship to you** _____
Address and Phone Number of Emergency Contact Person _____
Whom may we thank for referring you? _____
Who is responsible for this account? _____ **Relationship to patient** _____

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Insurance Company _____ **Group #** _____
Is patient covered by additional insurance? YES NO Subscriber's name _____
Subscriber's Birthdate _____ **Subscriber's SS#** _____ **Relationship to Patient** _____
Insurance company _____ **Group #** _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ **and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.**

_____ _____ _____
Responsible Party Signature **Relationship** **Date**

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DENTAL HISTORY

Reason for today's visit _____
Former Dentist _____ **City/State** _____
Date of last dental visit _____ **Date of last dental X-rays** _____
Please circle Yes or No to indicate if you have had any of the following:

Currently in pain	Yes	No	Bleeding gums	Yes	No	Blisters on lips or mouth	Yes	No
Burning sensation on tongue	Yes	No	Chew on one side of mouth	Yes	No	Cigarette, pipe or cigar smoking	Yes	No
Clicking or popping Jaw	Yes	No	Dry mouth	Yes	No	Fingernail biting	Yes	No
			Food collection between teeth	Yes	No	Chewing tobacco	Yes	No
Do you or have you ever experienced pain/discomfort in your jaw joint	Yes	No	Lip or cheek biting	Yes	No	Grinding teeth	Yes	No
	Yes	No	Jaw pain or tiredness	Yes	No	Swollen gums	Yes	No
Mouth breathing	Yes	No	Sensitivity when biting	Yes	No	Orthodontic treatment	Yes	No
Tender gums/ periodontal tissue	Yes	No	Sensitivity to sweets	Yes	No	Thumb or finger sucking habit	Yes	No
			Sensitivity to cold	Yes	No	Missing teeth	Yes	No
Loose teeth or broken fillings	Yes	No	Problems associated with previous dental work	Yes	No	Trauma to head/neck	Yes	No
Pain around ear	Yes	No				Type of toothbrush bristles	Hard	Medium Soft
Sensitivity to heat	Yes	No	Bad breath	Yes	No	Do you like your smile?	Yes	No
Sores or growths in in your mouth	Yes	No	How often do you brush? _____			Do you have any specific dental concerns?		
			How often do you floss _____			_____		

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MEDICAL HISTORY

Physician's Name _____ **Date of last visit** _____

Please circle yes or no to indicate if you have had any of the following:

AIDS	**Yes**	**No**	**Epilepsy**	**Yes**	**No**	**Psychiatric care**	**Yes**	**No**
Anemia	**Yes**	**No**	**Fainting or dizziness**	**Yes**	**No**	**Radiation treatment**	**Yes**	**No**
Arthritis, Rheumatism	**Yes**	**No**	**Glaucoma**	**Yes**	**No**	**Respiratory disease**	**Yes**	**No**
			Headaches	**Yes**	**No**	**Rheumatic fever**	**Yes**	**No**
Artificial heart valves	**Yes**	**No**	**Heart murmur**	**Yes**	**No**	**Scarlet fever**	**Yes**	**No**
			Heart problems	**Yes**	**No**	**Shortness of breath**	**Yes**	**No**
Artificial joints	**Yes**	**No**	**Hepatitis**	**Yes**	**No**	**Sinus trouble**	**Yes**	**No**
Asthma	**Yes**	**No**	**Type:** _____			**Skin rash**	**Yes**	**No**
Back problems	**Yes**	**No**	**Herpes**	**Yes**	**No**	**Special diet**	**Yes**	**No**
Bleeding abnormally (with extractions or surgery)	**Yes**	**No**	**High blood pressure**	**Yes**	**No**	**Stroke**	**Yes**	**No**
			Meds: _____			**Swelling of feet or ankles**	**Yes**	**No**
Blood disease	**Yes**	**No**	**HIV positive**	**Yes**	**No**			
Cancer	**Yes**	**No**	**Jaundice**	**Yes**	**No**	**Swollen neck glands**	**Yes**	**No**
Type:_____			**Jaw pain**	**Yes**	**No**	**Thyroid problems**	**Yes**	**No**
Chemical dependency	**Yes**	**No**	**Joint replacement**	**Yes**	**No**	**Tonsillitis**	**Yes**	**No**
Chemotherapy	**Yes**	**No**	**Kidney disease**	**Yes**	**No**	**Tuberculosis**	**Yes**	**No**
Circulatory problems	**Yes**	**No**	**Liver disease**	**Yes**	**No**	**Tumor or growth on head or neck**	**Yes**	**No**
			Low Blood Pressure	**Yes**	**No**			
Congenital heart Defect	**Yes**	**No**	**Mitral valve prolapse**	**Yes**	**No**	**Ulcer**	**Yes**	**No**
			Nervous problems	**Yes**	**No**	**Venereal disease**	**Yes**	**No**
Cortisone treatments	**Yes**	**No**	**Pacemaker**	**Yes**	**No**	**Weight loss, unexplained**	**Yes**	**No**
			Women:					
Cough, persistent or bloody	**Yes**	**No**	**Are you pregnant?**	**Yes**	**No**	**Any hospital stays**	**Yes**	**No**
			Due date _____			**Please explain** _____		
Diabetes	**Yes**	**No**	**Are you nursing?**	**Yes**	**No**	_____		
Do you wear contact lenses	**Yes**	**No**	**Are you taking birth control pills?**	**Yes**	**No**	_____		
						_____		

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MEDICATIONS

Please list medications you are currently taking:

_____

_____

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

Aspirin
Barbiturates (sleeping pills)
Codeine
Iodine
Latex
Metals
Local Anesthetic
Penicillin
Sulfa
Other _____

_____

_____

I understand that I may be charged a 1.5% finance charge per month (18% annually) if my balance goes beyond 90 days. I also understand that I am responsible for all fees pertaining to my unpaid balance and/or missed appointments.

I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to use my photographs for in-office patient education.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

_____ _____

Patient's signature **Date**

_____ _____

Signature of responsible party **Date**