



CONTEMPORARY
FAMILY DENTISTRY

WELCOME

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www.ContemporaryFamilyDentistry.com

PATIENT INFORMATION

Date: _____

Patient Name: _____

FIRST

MI

LAST

NICK NAME

Birth Date: _____ Sex: _____ Social Security #: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone: Home: _____ Cell: _____ Work: _____ Ext: _____

Email: _____

Employer: _____ Occupation: _____

Parents or Spouse Name: _____

Emergency Contact: _____ Phone: _____

Who may we thank for referring you? _____

DENTAL INSURANCE INFORMATION

Primary Insurance Company: _____

Insurance Co. Phone #: _____

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

Policy Holder Name: _____ Date of Birth: _____

Group#: _____ ID Number: _____

Policy Holders Employer: _____

Secondary Insurance Company: _____

Insurance Co. Phone #: _____

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

Policy Holder Name: _____ Date of Birth: _____

Group#: _____ ID Number: _____

Policy Holders Employer: _____

PATIENT MEDICAL HISTORY

Name of last dentist visited: _____

Where was your last dentist located? _____ Date of last appointment: _____

Does your last dentist have any recent x-rays of you? _____

Are you satisfied with your past dentistry? _____ Are you worried about receiving dental treatment? _____

Have you ever been told you have gum disease? _____ How often do you brush? _____ Floss? _____

Rate your smile 1 to 10, 10 being the best it could be. _____

Is there anything you would change about your smile????? _____

Do you have or have you had any of the following (circle which ones)

Abnormal Blood Pressure	Shortness of Breath	Glaucoma	Leukemia	Asthma/ Hay Fever
Stroke	Sinus Trouble	Thyroid Problems	Anemia	Sleep Apnea
Heart Murmur	Epilepsy	Liver Disease	Artificial Joints	Insomnia
Heart Ailment	Psychiatric Disorder	Kidney Disease	Tuberculosis	Ulcer
Pacemaker	Depression	Prolonged Bleeding	AIDS	Herpes
Congenital Lesion	Arthritis(rheumatic/ gouty/osteo)	Allergies	Hepatitis	Diabetes
Rheumatic Fever	Migraines/Headaches	Skin Rash	Venereal Disease	Cancer
Emphysema/Lung Disease		Latex Allergy		

Any major operations? _____

Date: _____

Date: _____

Date: _____

Procedure: _____

Procedure: _____

Procedure: _____

ANY MEDICATION CURRENTLY TAKING? _____ Birth Control? _____

VITAMINS/HERBS: _____

ANY ALLERGIES TO MEDICATION? _____

Do you take any medications to help you sleep? _____

Do you smoke? _____ Use alcohol? _____ Are you pregnant? _____

Physician's name: _____ Phone: _____ Date of last visit: _____

Are your teeth sensitive to?

_____ Hot _____ Cold _____ Sweets
_____ Biting Pressure _____ Previous Injury

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

_____ Clench of grind teeth _____ Loose, shifted or tipped teeth
_____ Clicking or gravel sounds in you jaw _____ Injury to face or Jaw
_____ Gum Surgery _____ Favor one side when chewing
_____ Sore or unhealed areas in mouth _____ Swollen or bleeding gums
_____ Frequent and or severe headaches _____ Chronic neck or shoulder pain
_____ Pain in jaw joint ears or side of face

Do you snore? YES NO Don't know

How likely are you to fall asleep in the following situation?

0 1 2 3
No chance Slight chance Moderate High chance
of dozing of dozing chance of of dozing
dozing

• Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Sitting inactive in a public place (e.g. theater or meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Sitting quietly after a lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• In a car, while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Score: _____
				NW : _____

The medical history above is accurate and complete to date and you have my permission to discuss any portion of this medical history with a physician. Furthermore, I consent to the use of those dental treatment procedures and anesthetics deemed necessary for dental treatment of the above named person.

Patient Signature (parent's signature if patient is under 18 years)

Date

OFFICE POLICIES PLEASE READ AND SIGN

FINANCIAL POLICY: I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure the payment of benefits. Accounts assigned to collections will be charged a \$50.00 collection fee. All balances over 60 days old will bear interest of 18% per annum or 1.5% per month.

INSURANCE: Payment of your **estimated** percentage is due at the time of treatment. If there is a difference between what the insurance pays and the **estimate** we collected the balance is due upon receipt of your account statement. Insurance is gladly billed as a courtesy to our patients, when you provide us with current information and any necessary forms. **All charges** are your responsibility whether or not they are covered by insurance. Insurance reimbursement is between you, your employer and the insurance carrier. **Benefits provided are not a guarantee of payment.** All patients are advised to contact their insurance for benefit and payment information.

