

## ABOUT YOU

NAME: \_\_\_\_\_

(Please List First, Middle, and Last Name.)

I PREFER TO BE CALLED: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

CIRCLE ONE:    MALE        FEMALE        AGE: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

HOME PHONE #: \_\_\_\_\_

WORK PHONE #: \_\_\_\_\_ EXT: \_\_\_\_\_

CELL PHONE OR PAGER #: \_\_\_\_\_

WHERE AND WHEN ARE THE BEST TIMES TO REACH YOU?

\_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

\_\_\_\_\_

OTHER FAMILY MEMBERS SEEN BY US: \_\_\_\_\_

\_\_\_\_\_

Welcome! The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we care for you.



## SPOUSE INFORMATION

HIS/HER NAME: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

WORK PHONE#: \_\_\_\_\_ EXT: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_

## PERSON RESPONSIBLE FOR ACCOUNT

NAME: \_\_\_\_\_

RELATION: \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_

HOME PHONE #: \_\_\_\_\_

WORK PHONE #: \_\_\_\_\_

BILLING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

## PRIMARY DENTAL INSURANCE

INSURANCE CO. NAME: \_\_\_\_\_

INSURANCE CO. PHONE #: \_\_\_\_\_

NAME OF EMPLOYER (IF COVERAGE IS THROUGH EMPLOYER):

\_\_\_\_\_

GROUP # (PLAN, LOCAL, OR POLICY#): \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_

RELATION: \_\_\_\_\_

SUBSCRIBER'S BIRTHDAY: \_\_\_\_\_

SUBSCRIBER'S SOCIAL SECURITY #: \_\_\_\_\_

## SECONDARY DENTAL INSURANCE

INSURANCE CO. NAME: \_\_\_\_\_

INSURANCE CO. PHONE #: \_\_\_\_\_

NAME OF EMPLOYER (IF COVERAGE IS THROUGH EMPLOYER):

\_\_\_\_\_

GROUP # (PLAN, LOCAL, OR POLICY#): \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_

RELATION: \_\_\_\_\_

SUBSCRIBER'S BIRTHDAY: \_\_\_\_\_

SUBSCRIBER'S SOCIAL SECURITY #: \_\_\_\_\_

**I AUTHORIZE MY INSURANCE COMPANY TO MAKE PAYMENT DIRECTLY TO GRANT RICKEY.**

**I UNDERSTAND THAT REGARDLESS OF MY INSURANCE COVERAGE AND BILLING ARRANGEMENT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF ALL MY DENTAL CHARGES.**

**SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_**

## MEDICAL HISTORY

Physician's Name: \_\_\_\_\_

Physician's Phone #: \_\_\_\_\_

Last Visit Date: \_\_\_\_\_

**In the event of an emergency, please list someone we may contact:**

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ EXT: \_\_\_\_\_

Home Phone #: \_\_\_\_\_

**Please list any prescription or over-the-counter medications that you are currently taking:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Have you ever had any of the following diseases or medical problems? (circle all that apply):**

Abnormal Bleeding	Epilepsy	Liver Disease
Anemia	Frequent Headaches	Seizures
Asthma	Heart Surgery	Shingles
Colitis	Hepatitis	Sinus Problems
Diabetes	Herpes	Stroke
Emphysema	Kidney Problems	Tuberculosis (TB)

### **For Women:**

Are you currently taking birth control pills?    YES    NO

**NOTE:** Antibiotics can render birth control pills ineffective.

Are you pregnant?    YES    NO

If yes, please list number of month(s) and/or weeks: \_\_\_\_\_

**Please list any medical condition that has not been asked:**

\_\_\_\_\_  
\_\_\_\_\_

**Please list any medications that you cannot take:**

\_\_\_\_\_  
\_\_\_\_\_

**Are you allergic to any of the following (circle all that apply):**

Aspirin	Penicillin	Latex
Tetracycline	Dental Anesthetics	

Other: \_\_\_\_\_

\_\_\_\_\_

## DENTAL HISTORY

Your Previous Dentist: \_\_\_\_\_

Approximate Last Visit Date: \_\_\_\_\_

Why have you come to the dentist today?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you currently in any dental related pain?

**YES    NO**

Please discuss any problems you have had with dental work:

\_\_\_\_\_  
\_\_\_\_\_

Do you have any pain or discomfort in your jaw joint?

**YES    NO**

The information that I have given is correct. It will be held in the strictest of confidence and I will inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have a question at any time, please ask us. We are happy to help!