WELCOME

About You

Today's date: ___/___/___

Patient's Name:_____

Last First

☐ Female

What You Prefer To Be Called:_____ ☐ Male

Birth Date:___/___/___ Age:_____

SS # : _____

Mailing Address: _____

_____

City State Zip

Home Phone # :(____)_____

Work Phone: (____)_____

Cell Phone: (____)_____

Referred By: _____

Employer:_____

Employer's Address: _____

_____

City State Zip

Occupation: _____

Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Spouse's Name:_____

Do You Have Children? ☐Yes ☐No How Many?_____

Account Information

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____

City State Zip

SS # :_____

Driver's License # : _____

Work Phone # : (____)_____

Payment Method: ☐Cash ☐Check ☐Credit Card

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Initials

Insurance Information

Primary Dental Insurance

Co. Name: _____

Address: _____

_____

City State Zip

Phone # : (____)_____

Insured's ID# :_____

Group # : (Plan, Local, or Policy #)

_____

Insured's Name: _____

Relation: _____Birth Date: __/__/__

Insured's Employer: _____

Secondary Dental Insurance

Co. Name:_____

Address: _____

_____

City State Zip

Phone # :(____)_____

Insured's ID# :_____

Group # : (Plan, Local, or Policy #)

_____

Insured's Name: _____

Relation: _____Birth Date: __/__/__

Insured's Employer: _____

In Event of Emergency

Whom should we contact? _____

Relation: _____

Home Phone # : (____)_____

Work Phone # :(____)_____

Cell Phone # :(____)_____

Who is your Medical Doctor?_____

Medical Doctor's Phone # :(____)_____

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Rank Your Dental Concerns

#1 = Most Important & #4 Least

__ Health
__ Cost
__ Appearance
__ Function

Smile Evaluation

Are you happy with the appearance of your teeth/gums/smile? Y N

What don't you like about your smile?

_____

Would you like to make your teeth whiter? Y N

Dental Information

Reason for today's visit: ☐Exam ☐Emergency ☐Consultation ☐Cleaning

Are you in pain? ☐Yes ☐No How long?_____

Please indicate any of the following problems:

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

☐Other:_____

Do you require pre-medication?☐ Yes ☐ No Medication name?_____

Previous Dentist:_____ Phone # :(___)_____

Last Dental exam:___/___/___Last Dental x-rays:___/___/___

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

What type of tooth brush bristles you use? ☐Soft ☐Medium ☐Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

Medical History

Please list all medications you are taking: _____

_____

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

Y	N		Y	N		Y	N		Y	N	
☐	☐	Heart Attack / Stroke	☐	☐	Thyroid Problems	☐	☐	Cancer/Tumors	☐	☐	Cosmetic Surgery
☐	☐	Heart Surg./Pacemaker	☐	☐	Kidney Problems	☐	☐	Shingles	☐	☐	Xray Cancer Treatment
☐	☐	Heart Murmur	☐	☐	Liver Problems	☐	☐	Hepatitis	☐	☐	Chemotherapy
☐	☐	Rheumatic Fever	☐	☐	Respiratory Problems	☐	☐	HIV+/AIDS/ARC	☐	☐	Asthma
☐	☐	Mitral Valve Prolapse	☐	☐	Sinus Problems	☐	☐	Arthritis/Rheumatism	☐	☐	Difficulty Breathing
☐	☐	Artificial Valves	☐	☐	Stomach Problems/Ulcers	☐	☐	Artificial Bones/Joints	☐	☐	Diabetes/Hypoglycemia
☐	☐	Heart Disease	☐	☐	Psychiatric Problems	☐	☐	Emphysema	☐	☐	Leukemia
☐	☐	Congenital Heart Defect	☐	☐	Venereal Disease	☐	☐	Fainting/Seizures/Epilepsy	☐	☐	Anemia
☐	☐	Chest Pains	☐	☐	Alcohol/Drug Abuse	☐	☐	Severe/Frequent Headaches	☐	☐	High/Low Blood Pressure
☐	☐	Scarlet Fever	☐	☐	Tuberculosis TB	☐	☐	Frequent Neck Pain	☐	☐	Bleeding Problems
☐	☐	Nervousness	☐	☐	Jaw Problems TMJ/TMD	☐	☐	Back Problems	☐	☐	Glaucoma

Please list any other surgeries or medical conditions you have or ever had: _____

Are you allergic to any of the following? ☐Latex ☐Penicillin/Amoxicillin ☐Tetracycline ☐Aspirin ☐Dental Anesthetics

☐Others:_____ Do you drink alcohol? ☐No ☐Yes How much? _____

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

Please rate your general health from (Worst) 1 2 3 4 5 6 7 8 9 10 (Best) Do you wear contact lenses? ☐No ☐Yes

For Women: Are you taking Birth Control pills? ☐No ☐Yes Are you Pregnant? ☐No ☐Yes/How long?_____

Are you nursing? ☐No ☐Yes

→ 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 including photographs which may be used for instructive purposes. 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 best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ **Date** _____/_____/_____

☐Adult Patient ☐Parent or Guardian ☐Spouse

Please send a copy of my complete treatment record and original radiographs ("x-rays") from the last 2 years to:

Mary C. Squire, D.D.S.

P.O. Box 1724

Manchester Center, VT 05255

Thank You.

_____

Name