MAIN STREET DENTAL

Thank you for choosing us! We want your visit to be pleasant and comfortable. Please help us by completing this form.

Personal Information

Name of Patient _____ DOB _____ Age _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail Address _____

Marital Status: □ Single □ Married

Gender: □ M □ F

Employer _____ Occupation _____

In case of emergency, who should be notified? _____ Phone _____

Whom may we thank for referring you? _____

If Patient is a Minor:
Name of Patient's Authorized Representative _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Relationship to Patient _____

Insurance Information

Primary Dental Insurance

Subscriber Name _____ Insurance Identification # _____ DOB _____

Employer _____ Group # _____

Insurance Company _____ Insurance Company Phone _____

Relationship to Patient _____

Secondary Dental Insurance

Subscriber Name _____ Insurance Identification # _____ DOB _____

Employer _____ Group # _____

Insurance Company _____ Insurance Company Phone _____

Relationship to Patient _____

Continued on the next page…

Dental History

Reason for today's visit? _____

Last dental exam? _____ Last dental x-rays? _____ Previous dentist? _____

Are you nervous about receiving dental treatment?	□ Yes □ No
Do you smoke or use chewing tobacco?	□ Yes □ No
Do your gums bleed when brushing or flossing?	□ Yes □ No
Have you ever been diagnosed with periodontal disease?	□ Yes □ No
Does your jaw "pop" or "click" when opening or closing?	□ Yes □ No
Have you ever had orthodontic treatment?	□ Yes □ No
Do you brush daily?	□ Yes □ No
Do you floss daily?	□ Yes □ No

If you could change anything about your smile, what would it be? _____

Medical History

Physician's Name _____ Physician's Phone _____

Have you ever been hospitalized or had a major operation? □ Yes □ No

Please explain

_____

Have you ever had an unusual reaction to dental anesthetic? □ Yes □ No

Please explain

_____

Are you taking any medications, pills, or drugs? □ Yes □ No

Please explain

_____

Are you allergic to any medications or substances? □ Yes □ No

□ Acrylic □ Codeine □ Iodine □ Latex □ Metals □ Milk □ Penicillin □ Sulfa □ Other _____

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

AIDS/HIV	□ Y □ N	Heart Attack	□ Y □ N	Mental Disorders	□ Y □ N
Alcoholism	□ Y □ N	Heart Murmur	□ Y □ N	Mitral Valve Prolapse	□ Y □ N
Anemia	□ Y □ N	Heart Surgery (Stents)	□ Y □ N	Pacemaker	□ Y □ N
Arthritis	□ Y □ N	Hemophilia	□ Y □ N	Prosthetic Heart Valve	□ Y □ N
Asthma	□ Y □ N	Hepatitis A, B, or C	□ Y □ N	Respiratory Problems	□ Y □ N
Cancer	□ Y □ N	High Blood Pressure	□ Y □ N	Rheumatic Fever	□ Y □ N
Congenital Heart Defect	□ Y □ N	Joint Replacement	□ Y □ N	STD's	□ Y □ N
Diabetes	□ Y □ N	Kidney Problems	□ Y □ N	Stroke	□ Y □ N
Drug Addiction	□ Y □ N	Liver Problems	□ Y □ N	Thyroid Problems	□ Y □ N
Epilepsy/Seizures	□ Y □ N	Low Blood Pressure	□ Y □ N	Tuberculosis	□ Y □ N

Do you have any conditions/diseases that are not listed above? □ Yes □ No

Please explain

_____

WOMEN: □ Oral Contraceptives □ Pregnant □ Nursing

Continued on the next page…

Disclosure Consent

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment and payment.

Insurance Authorization Statement

I authorize payment directly to the dental office for the insurance benefits otherwise payable to me. I understand that my dental insurance may pay less than the actual bill for services, and that I am financially responsible for all costs relating to the dental care of my family and/or myself.

Treatment Authorization

I authorize the dentist and the staff of the dental office to perform necessary dental services, including but not limited to x-rays and the administration of anesthesia. In addition, the above authorization applies to my child whether or not I am present when treatment is rendered.

_____

Signature of Patient or Patient's Authorized Representative *Date*

_____

Name of Patient's Authorized Representative (please print)

_____

Description of Legal Authority to Act on Behalf of Patient