

**PRESCOTT** *Welcome* to our dental office  
 Family Dental 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 can care for you

About You

Today's Date: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 I prefer to be called: \_\_\_\_\_ M  F   
 Birth date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ SS#: \_\_\_\_\_  
 Home Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Single  Married  Partnered  Divorced/Separated  Widowed   
 Hm#: ( ) \_\_\_\_\_ Cell#: ( ) \_\_\_\_\_  
 Wk#: ( ) \_\_\_\_\_ Ext: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 How Long there? \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Are we able to confirm appointments by:  
 Text: yes  no  Email: yes  no   
 Whom may we thank for referring you? \_\_\_\_\_  
 Other family members seen by us? \_\_\_\_\_  
 Previous Dentist: \_\_\_\_\_  
 Date of last visit: \_\_\_\_\_

Spouse Information

His / Her Name: \_\_\_\_\_  
 Cell# \_\_\_\_\_  
 Wk#: ( ) \_\_\_\_\_ Ext: \_\_\_\_\_  
 Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Wk#: ( ) \_\_\_\_\_ Hm#: ( ) \_\_\_\_\_  
 Cell#: ( ) \_\_\_\_\_

HIPAA

I have received a copy of this office's Notice of Privacy Practices  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Primary Dental Insurance

Insured's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Insured's Employer \_\_\_\_\_  
 Group# (Plan, Local or Policy#) \_\_\_\_\_  
 Insurance Co. Name: \_\_\_\_\_  
 Insurance Co. Address: \_\_\_\_\_  
 Insurance Co. Phone#: ( ) \_\_\_\_\_  
 Insured's Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Insured's SS# of ID# \_\_\_\_\_

Secondary Dental Insurance

Insured's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Insured's Employer \_\_\_\_\_  
 Group# (Plan, Local or Policy#) \_\_\_\_\_  
 Insurance Co. Name: \_\_\_\_\_  
 Insurance Co. Address: \_\_\_\_\_  
 Insurance Co. Phone#: ( ) \_\_\_\_\_  
 Insured's Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Insured's SS# of ID# \_\_\_\_\_

This office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dentist (or dental group) insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment.

I, the undersigned, understand and agree that there will be an interest charge of 1.5% per month of any past due account over 90 days. I also understand and agree that if I am in default of this agreement, I will pay all reasonable legal fees, court costs, and other costs necessary to collect the debt, including fees charged by a collection agency.

I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

**Payment is due in full at the time of treatment**  
 unless prior arrangements have been approved.

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

Our office is HIPAA compliant and is meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

# Medical History

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No
- Do you use tobacco?  Yes  No
- Do you use controlled substances?  Yes  No

Woman: Are You \_\_\_\_\_

Pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing  Yes  No

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Local Anesthetics  Acrylic  Metal  Latex  Sulfa drugs

Other If yes, please explain: \_\_\_\_\_

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

AIDS /HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Dis.	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problem	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No						

Have you ever had any serious illness not listed above?  Yes  No \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Dental Concerns: \_\_\_\_\_

\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_