***Patient Information*** *(CONFIDENTIAL)*

Name ______________________________________________ Preferred Name ________________

Title ___________ Gender: ☐ Male ☐ Female Family Status ☐ Married ☐ Single ☐ Child

Birth Date ________________ Social Security # _____________ Home Ph _____________________

Mobile Ph ___________________ Work Ph ________________ Employer _____________________

Address _________________________________ City ____________ State _____ Zip Code _______

E-mail: ____________________________________________________________________________

Which is the best form of contact? ☐ Home ☐ Work ☐ Mobile ☐ Text Message ☐ Email

Whom may we thank for referring you to our practice? _______________________________________

**Primary Dental Insurance Information**

Name of Insured ____________________________________________________________________

Insured's Birth Date ________________________ Subscriber ID # ______________Group # _______

Employer Name ___________________________ Relationship to insured: ☐ Self ☐ Spouse ☐ Child

Insurance Carrier Name _________________________________ Insurance Phone ______________

Insurance Address_______________________ City _____________ State ______ Zip Code _______

**Consent for Services**

<u>As a condition of treatment by this office, financial arrangements must be made in advance. In all cases requiring lab work such as crowns, dentures or bridges we request a minimum down payment of 50%.</u>

If choose to be contacted via text or email I authorize Uptown Cosmetic & Implant Dentistry to send electronic appointment reminders to me. I understand text charges from my cell phone provider may apply. I understand that email may not be the safest form of communication as they can be intercepted during transmission

I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health care practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. <u>I understand that if my insurance carrier has not paid for services rendered by 90 days I will have to pay any balance on my or my dependents account</u>. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered.

_____________________________________________ ____________________________

Signature of Patient (or parent if minor) Date

**PATIENT HEALTH HISTORY**

Physician __________________________Physician Ph ____________ Date of Last Exam_________

1. Are you under medical treatment? □ Yes □ No
2. Have you been hospitalized for any surgical operation or serious illness within the last 5 yrs? □ yes □ No If yes, please explain __________ ________________________________________
3. Are you taking any medication(s) including non-prescription medications? □ Yes □ No Please list _______________________________ ________________________________________ ________________________________________ ________________________________________
4. Do you use tobacco? □ Yes □ No

5. Are you allergic to or have had any reactions to the following (check all that apply)
□ Local Anesthetics (e.g. Novocaine)
□ Penicillin or any other antibiotic
□ Sulfa Drugs
□ Barbiturates
□ Iodine
□ Aspirin
□ Any metals (e.g. nickel, mercury, etc)
□ Latex Rubber
□ Other ______________________

6. Women only: Are you pregnant or think you may be pregnant? □ Yes □ No
*For those patients using oral contraceptives: Please be advised that the use of certain antibiotics can reduce the effectiveness of Birth Control. If you have any concerns, please speak with the doctor.

7. Do you have or have you had any of the following? (check all that apply) Please note: If you do not check a box it will be assumed you do not have the condition.

□ High Blood Pressure
□ Swollen Ankles
□ Low Blood Pressure
□ Diabetes
□ Thyroid Problem
□ Heart Murmur
□ Cancer
□ Hepatitis/ Jaundice
□ Chest Pains
□ Hay Fever/Allergies
□ Glaucoma
□ Heart Trouble
    □ Heart Attack

□ Fainting/Seizures
□ Epilepsy/Convulsions
□ Kidney Disease
□ Heart Disease
□ Angina
□ Arthritis
□ Sexually Transmitted Disease
□ Easily Winded
□ Tuberculosis
□ Recent Weight Loss
□ Respiratory Problems
□ Rheumatic Fever

□ Asthma
□ Leukemia
□ AIDS or HIV Infection
□ Cardiac Pacemaker
□ Emphysema
□ Joint Replacement or Implant
□ Stroke
□ Radiation Therapy
□ Liver Disease
□ Mitral Valve Prolapse

**PATIENT DENTAL HISTORY**

Reason for Today's Visit_____________________________________ Last Dental Visit___________
For what reason was your previous dental visit ____________________ Previous Dentist ___________

1. Do you experience any of the following? (Check all that apply)

□ Bleeding gums
□ Teeth sensitivity to sweet or sour liquids/foods
□ Teeth sensitivity to hot or cold liquids/foods
□ Pain in any of your teeth
□ Sores or lumps in or near mouth
□ Frequent headaches
□ Clench or grind teeth
□ Bite lips or cheeks frequently

2. Have you had any head, neck or jaw injuries? □ Yes □ No
3. Have you experienced any of the following problems in your jaw? (check all that apply)

□ Clicking
□ Difficulty in chewing
□ Pain (joint, ear, side or face)
□ Difficulty in opening or closing

4. Have you ever had prolonged bleeding following extractions? □ Yes □ No
5. Have you had any orthodontic treatment? □ Yes □ No
6. Do you wear dentures or partials? □ Yes □ No If yes, date of placement ______________________
7. Have you ever received oral hygiene instructions? □ Yes □ No
8. Do you like your smile? □ Yes □ No
9. If by magic you could change anything about your teeth, what would you change? ____________________

Additional Comments: ______________________________________________________________

Signature: ____________________________ Date: ___________________