Welcome!

Patient Information (Confidential)

Patient Name_____Parent/Guardian Name_____

Birthdate_____Sex_____Soc.Sec.#_____Driver's License #_____

Home Address_____City_____State_____Zip_____

Home Phone_____Work_____Cell_____

E-Mail_____

Employer_____Occupation_____How Long There?_____

Spouse's Name (or other parent/guardian)_____Soc Sec.#_____

Spouse's Employer_____Occupation_____How Long There?_____

If patient is a student: Name of School/College_____Full-time or part?_____

How did you hear about our office?_____

Primary Insurance

Name of Insured_____

Birthdate_____ Relationship to patient _____

Insurance Company_____

Insurance Address_____

Insurance Phone_____

Soc.Sec.#_____

SubscriberID#_____

Group, Contract or Local or Union # _____

Additional Insurance

Name of Insured_____

Birthdate_____ Relationship to patient _____

Insurance Company_____

Insurance Address_____

Insurance Phone_____

Soc.Sec.#_____

SubscriberID#_____

Group, Contract or Local or Union # _____

Copayments

To accept insurance, we now debit copayments automatically to your credit card or bank account. If you would like us to accept your insurance, please provide credit card information or voided check.

☐ MC ☐ VISA ☐ AMEX ☐ Discover Account #_____Expiration Date_____

Name on Card _____Billing Address_____

☐Voided Check Attached

In case of emergency

Physician's name_____City_____Phone_____

Someone we may contact, not living with you_____Phone_____

Agreement to pay for treatment and authorization to automate co-payments

I hereby acknowledge full responsibility for the payment of services rendered in behalf of the named patient whether or not they are covered by insurance. I understand payment is expected at the time of service. I understand that in certain circumstances my credit report may be requested. I understand that check payments may be converted to automatic bank drafts. I agree that if payment is extended beyond 30 days from the date of service to pay a rebilling charge of 1.7% of the unpaid balance, with minimum rebilling charge of $5.00 per month. I agree to pay collections costs and/or attorney's fees if a delinquent balance is placed with an agency for collection. I authorize my insurance company to make payments directly to the dental office for the benefits otherwise payable to me. I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities as deemed necessary by this office. I authorize use of this signature for all insurance submissions. I authorize this office to charge my credit card or bank account for any unpaid balances, including those after insurance payment. I have received a copy of this office's Notice of Privacy Practices. I understand that appointments missed or cancelled without 24 hours notice are subject to a $35 cancellation fee. I understand that a deposit may be required to reserve certain appointment types and/or times. I understand estimates of treatment cost are valid for 90 days. I have reviewed the information on this form, and it is accurate to the best of my knowledge.

Signature:_____Date_____

Medical History

Have you been hospitalized? Please explain._____

Are you under the care of a physician or planning to see one for any reason? Please explain._____

_____

List any medications you are currently taking._____

_____

Do you smoke? How much/day?_____ Do you drink alcohol? Drinks/week?_____

Pregnant? Due Date_____ Nursing?_____

Allergies: □ penicillin □ sulfa □ local anesthetics □ codeine □ latex □ metal □ other_____

Please check all that apply:

- □ AIDS/HIV+
- □ Alzheimer's Disease
- □ Anemia
- □ Angina
- □ Arthritis/Gout
- □ Artificial Heart Valve
- □ Artificial Joint
- □ Asthma
- □ Blood disease
- □ Bruise Easily
- □ Cancer
- □ Congenital Heart Disorder
- □ Diabetes
- □ Drug Addiction
- □ Emphysema
- □ Epilepsy or Seizures
- □ Excessive bleeding
- □ Excessive thirst
- □ Fainting Spells/Dizziness
- □ Frequent headaches
- □ Glaucoma
- □ Heart attack/failure
- □ Heart murmur
- □ Heart pacemaker
- □ Heart trouble/Disease
- □ Hemophilia
- □ Hepatitis A
- □ Hepatitis B or C
- □ High blood pressure
- □ Hypoglycemia
- □ Kidney Disease/Problems
- □ Liver Disease/Problems
- □ Low Blood Pressure
- □ Lung Disease/Problems
- □ Mitral valve prolapsed
- □ Pain in jaw joints
- □ Parathyroid disease
- □ Psychiatric Care
- □ Rheumatic Fever
- □ Sinus Problems
- □ Stomach/Intestinal Disease
- □ Stroke
- □ Thyroid Disease
- □ Tonsilitis
- □ Tuberculosis
- □ Tumors or Growths
- □ Ulcers
- □ STD/Venereal Disease

Any other illness not checked above_____

Please indicate if you would prefer to speak privately with the dentist about a medical issue: □ yes □ no

Dental History

Reason for seeking care today: □ Exam □ Cleaning □ Specific Problem _____

Please check all that apply:

- □ Toothache
- □ Broken filling or tooth
- □ Chipped tooth or teeth
- Sensitivity to:
  - □ Cold
  - □ Heat
  - □ Sweets
  - □ Chewing
- □ Food Catches
- □ Loose teeth
- □ Missing teeth
- □ Floss breaks or hurts
- □ Bite or teeth shifted
- □ Bite cheeks
- □ Dry mouth
- □ Bad breath
- □ Unhappy with previous dental work
- □ Gums bleed
- □ Gums tender
- □ Growths or sores
- □ Cold sores/fever blisters
- □ Cracked/chapped lips
- □ Bad taste in mouth
- □ Clench or Grind teeth
- □ Clicking or popping jaw joint
- □ Unable to open wide
- □ Jaw tires easily
- □ TMJ or TMD
- □ Wisdom Teeth
- □ Had braces
- □ Want braces
- □ Prior gum treatment
- □ Prior bite treatment
- □ Snore or don't sleep well
- □ Play sports
- □ Embarrassed about teeth
- □ Gag easily
- □ Dislike dental office noises
- □ Don't like cotton in mouth
- □ Uncomfortable lying in dental chair
- □ Afraid of needles
- □ Difficult to numb
- □ Reaction to anesthetic
- □ Worried about costs
- □ Worried about time

Would you like whiter teeth? □ yes □ no Is there anything that bothers you (even just a little) about the appearance of your teeth or smile?_____

_____

On a scale from 1-10 how anxious are you about dental treatment?(1=relaxed, 10=scared)_____

What did you like most about your last dentist?_____

Why did you leave your last dentist?_____

Did your parents have difficulties with their teeth or dental treatment?_____

Is there anything we can do to make your visits more comfortable?_____

Consent for treatment

To the best of my knowledge the questions on this form have been accurately answered. I will inform Legacy Dental of any changes to these answers. I authorize Legacy Dental and its associates to perform those procedures deemed necessary or advisable to maintain my dental health or the dental health of my child. I understand that dental treatment and anesthesia entails risks such as bleeding, infection, nerve damage, fracture of teeth or bone, injury to muscles, bruising, muscle soreness, swallowing or inhaling small objects, breakage of instruments, pain during and after treatment, abrasions and lacerations to gums, cheeks, or tongue. I do voluntarily assume all possible risks that may be associated with dental treatment in hopes of obtaining the desired results.

Signature:_____Date:_____