Denton Family Dental

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form completely. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date: __________Home Phone (____) ______________Cell Phone (____)_______________
Name: ______________________________ SS#____
Address: ____________________________ E-Mail:_____________________________________
City: __________________________ State: ________________ Zip: _______________________
Sex: __M ___F Age: _______ Birthdate: _________________________________
__ Married ___ Widowed __ Single __ Minor __ Separated __ Divorced
Whom may we thank for referring you? ____
In case of emergency who should be notified? __________________ Phone ____________

Primary Insurance

Person Responsible for Account: ____
Relation to Patient: __________________ Birthdate: ____________ SS#: _______________
Address: (if different from patient's) ____
Phone: (__) ________________City: ________________ State: _________ Zip: __________
Person Responsible Employed by: ________________Occupation:_______________________
Business Address: ____________________________ Business Phone: (__) ______________
Insurance Company: _______________Dental/Member Services Number______________
Subscriber #: ______________________ Group#: _____________________________________
Names of other dependents covered under this plan: ______________________________

Dental History

Reason For Today's Visit: ___________________ Date Of Last Dental Care: ______________
Former Dentist: ___________________________ Date of last dental x-rays: ______________
Address: ____

Check (✓) if you have had any of the following:

_____ Sores or growth in your mouth
_____ Loose teeth or broken fillings
_____ Periodontal treatment
_____ Food collection between teeth
_____ Sensitivity to hot
_____ Sensitivity to sweets
_____ Sensitivity when biting
_____ Sensitivity to cold
_____ Bleeding Gum
_____ Clicking or Popping
_____ Grinding
_____ Bad breath

How often do you floss? ___________ How often do you brush? ___________

Medical History

Physician's name: _________________________ Date of last visit: _________________________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of lonimin, Adipex, Fastin(brand names of phentermine), Pondimin(fenfluramine) and Redux(dexfenfluramine). _____ Yes _____ No

Have you had any serious illnesses or operations? ____ Yes ____No
If yes describe: ____
Have you ever had a blood transfusion? _____ Yes _____No
If yes give approximate dates: ____
(WOMEN) Are you pregnant? _____ Yes _____ No Nursing? ______ Yes ______ No
Taking birth control pills? ______Yes _____No

Please circle if you have or have had any of the following:

Anemia	**Cortisone Treatment**	**Hepatitis**	**Scarlet Fever**
Arthritis, Rheumatism	**Cough, Persistent**	**High Blood Pressure**	**Shortness of breath**
Artificial Heart Valves	**Cough up blood**	**HIV/Aids**	**Skin Rash**
Artificial Joints	**Diabetes**	**Jaw Pain**	**Stroke**
Asthma	**Epilepsy**	**Kidney Disease**	**Swelling of feet/ankles**
Back problems	**Fainting**	**Liver disease**	**Thyroid problems**
Blood disease	**Glaucoma**	**Mitral Valve prolapse**	**Tobacco habit**
Cancer	**Headaches**	**Pacemaker**	**Tonsillitis**
Chemical Dependency	**Heart Murmur**	**Radiation Treatment**	**Tuberculosis**
Chemotherapy	**Heart problems**	**Respiratory disease**	**Ulcer**
Circulatory Problems	**Hemophilia**	**Rheumatic fever**	**Venereal disease**

Other: ____

Are you taking any medications: ____?
Are you allergic to any medications: ____?

I certify that I, and/or my dependent(s), have insurance coverage with ____________________________________ And assign directly to Dr.___________________________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

I certify that the information above is correct and complete.

____ ______________________________________
Signature of patient, parent, guardian or personal representative Date

____
Please print name of patient, parent, guardian or personal representative

____
Relationship to patient