

Welcome

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: _____ E-mail Address: _____

Name: _____ Name I prefer to be called: _____ Male Female
Last First MI Mr. Mrs. Ms. Dr.

Birthdate: ___/___/___ Age: _____ SSN: _____ Single Married Divorced Widowed Separated

Home Address _____
Street City State Zip

Mailing Address: _____
Street City State Zip

Home Phone #: (____) _____ Cell #: (____) _____ Work Phone #: (____) _____ Ext: _____

How did you hear about us? Web Site Yellow Pages Driveby Insurance listing Friend or Family Member Other _____

Who is the friend or family member we may we thank for referring you? _____

Other family members seen by us: _____

Your Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State Zip

Spouse or Emergency Contact Information

His/Her Name: _____ Birthdate: ___/___/___ Relationship: _____

Home Phone #: (____) _____ Cell #: (____) _____ Work Phone #: (____) _____ Ext: _____

Insurance Information

Primary Insurance Co. Name: _____ Phone #: (____) _____ Group #: _____

Insured's Name: _____ Insured's SSN: _____

Insured's Address: _____
Street City State Zip

Insured's Birthdate: ___/___/___ Relationship: _____ Insured's Employer: _____

Secondary Insurance Co. Name: _____ Phone #: (____) _____ Group #: _____

Insured's Name: _____ Insured's SSN: _____

Insured's Address: _____
Street City State Zip

Insured's Birthdate: ___/___/___ Relationship: _____ Insured's Employer: _____

Dental History

Why have you come to the dentist today? _____

Are you currently in pain? Yes No

Do you require antibiotics for dental treatment Yes No

Your current dental health is Good Fair Poor

Do you floss daily? Yes No Brush daily? Yes No

Type of toothbrush? Manual Battery Electric

Do your gums bleed? Yes No Ever itch Yes No

Have you ever had periodontal disease? Yes No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you have any loose teeth? Yes No

Previous Dentist: _____ Last Visit Date _____

Why did you leave your last dentist? _____

Are you satisfied with the appearance of your teeth? Yes No

If No, what would you like to change? (Circle all that apply)

Length, Color, Spaces, Crowding, Other: _____

Have you ever had any serious complications with prior dental treatment? Yes No

If Yes, what? _____

Have you had any head, neck, or jaw injuries? Yes No

Do you have frequent headaches? Yes No

Have you ever experienced any of the following problems in your jaw?

Clicking? Yes No

Pain (joint, ear, side of face)? Yes No

Difficulty in opening or closing? Yes No

Difficulty in chewing? Yes No

Do you clench or grind your teeth? Yes No

Have you had any orthodontic work? Yes No

Have you ever whitened your teeth? Yes No

If yes, what type of product? _____

What is your ultimate goal in seeking dental care?

- Be out of pain only
- Have healthy mouth, but I'm okay with my smile
- Have a perfect "Hollywood smile"

Medical History

Do you have a personal physician? Yes No

Physician's Name: _____

Phone #: (____) _____ Date of last visit: _____

Your current health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Do you smoke or use tobacco in any other form? Yes No

Have you ever taken Phen-fen, Redux, or Pandimin? Yes No

For Women: Are you taking birth control pills? Yes No

Are you pregnant? Unsure Yes No

Week #: _____ Are you nursing? Yes No

Are you allergic to any of the following?

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin | <input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N Latex | <input type="checkbox"/> Y <input type="checkbox"/> N Sulfa Drugs |
| <input type="checkbox"/> Y <input type="checkbox"/> N Barbiturates | <input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin | <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin | <input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline |
| <input type="checkbox"/> Y <input type="checkbox"/> N Codeine | <input type="checkbox"/> Y <input type="checkbox"/> N Jewelry / Metals | <input type="checkbox"/> Y <input type="checkbox"/> N Sedatives | <input type="checkbox"/> Y <input type="checkbox"/> N Other |

Please list anything additional that causes allergic reactions: _____

Do you have or have you ever experienced the following?

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Alcohol Abuse | <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Drug Abuse | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes | <input type="checkbox"/> Y <input type="checkbox"/> N Scarlet Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema | <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Seizures |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Joints | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N HIV / AIDS | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Valves | <input type="checkbox"/> Y <input type="checkbox"/> N Ever Hospitalized | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion | <input type="checkbox"/> Y <input type="checkbox"/> N Fever Blisters | <input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Steroid Therapy |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Lupus | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chicken Pox | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Bone medication | <input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Colitis | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB) |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Persistent Cough | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcers |
| | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Problems | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease |

Please list any serious medical conditions that you have experienced: _____

Are you taking any prescriptions/over the counter drugs, blood thinners, or heart medications? Yes No

If Yes, please list each one: _____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I understand that I am responsible for payment of services rendered. I authorize my insurance benefits to be paid directly to this office and allow release of any information required by my insurance.

Signature Date

Medical History Update

I have read my medical history dated _____ and confirm that it states past and present medical condition _____
Initial Date

I have read my medical history dated _____ and confirm that it states past and present medical condition _____
Initial Date

I have read my medical history dated _____ and confirm that it states past and present medical condition _____
Initial Date

I have read my medical history dated _____ and confirm that it states past and present medical condition _____
Initial Date

Financial Policy

Thank you for choosing us to serve your dental needs. We strive continually to offer you the best possible care available. In helping us to achieve that level of excellence, we ask that you understand and agree to the following information regarding our level of commitment to you and the commitment we ask in return.

Our commitment to you:

- We will call to confirm your reservation with us two working days in advance of your appointment.
- We will always strive to be prompt in having your room reserved for the time we have given you. In the case of an unexpected event that may disrupt our schedule, we will communicate to you what we are doing to keep your reservation.
- We will always recommend for you the best treatment available to treat any dental needs you have and explain any risks, benefits, and alternatives to that treatment and we will answer all of your questions to your satisfaction.
- We will, as a courtesy to you, bill your insurance company and do our best to work with them to resolve any conflicts that may arise. We will also keep you informed of any new information we receive regarding your insurance claims.

Our requests of you:

- If you do need to change your reservation in our office, we request at least 24 hours notice so that we may have adequate time to offer that time to someone else who is awaiting treatment.
- Understand that the treatment that is indicated in your condition may be covered only partially by your insurance plan or it may not be covered at all. Please do not make us lower our standards of care because your insurance says that they do not cover a necessary procedure.
- Understand that you are responsible for any portion of your bill that your insurance does not cover. Most insurance companies will pay their portion within 30 to 45 days. If your insurance does not pay after 60 days, you will become responsible for that portion of your bill, however, it will be refunded if the insurance company pays later.
- We request that you pay your portion at the time your service is rendered. We accept cash, check, Visa, Mastercard, Discover, or we also offer extended payment plans with Wells Fargo and CareCredit.

I have read and understand the level of service being offered to me and the commitment I am making as a patient in the office of Dr. Bingham & Dr. Jenkins.

Signature_____

Date_____