Welcome to Country Club Dental

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

PATIENT INFORMATION

Today's Date:_____

NAME:_____
Last, First MI

I prefer to be called:_____ Male ☐ Female ☐

Birthdate:_____Age:____SSN:_____

ADDRESS:_____
Street Apartment #

_____
City State Zip Code

_____
E-Mail Address

Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

Home Phone:_____Cell:_____

Work Phone:_____Ext._____DL:_____

Employer:_____

Employer's Address:_____

How long there?_____Occupation:_____

Where & when are best times to reach you?_____

Whom may we thank for referring you?_____

Other family members seen by us:_____

Previous / Present Dentist:_____

Date of last visit:_____Are you a full time Student?_____

Which school do you attend?_____

In what city?_____

RESPONSIBLE PARTY

His / Her Name:_____

Employer:_____

Birthdate:_____SSN:_____

Work Phone:_____Ext._____DL:_____

PERSON RESPONSIBLE FOR ACCOUNT:_____

Work Phone:_____Ext._____HM#:_____

Billing address:_____

Relationship:_____SSN:_____

Employer:_____DL:_____

DENTAL INSURANCE

PRIMARY DENTAL INSURANCE

Insurance Co. Name:_____

Insurance Co Address: _____
Street

_____
City State Zip Code

Insurance Co. Phone:_____

Group# (Plan, Local, Policy#)_____

Insured's Name:_____Relation:_____

Insured's Birthdate:_____SSN:_____

Insured's Employer:_____

Insured's Address: _____
Street

_____
City State Zip Code

SECONDARY INSURANCE

Insurance Co. Name:_____

Insurance Co Address: _____
Street

_____
City State Zip Code

Insurance Co. Phone:_____

Group# (Plan, Local, Policy#)_____

Insured's Name:_____Relation:_____

Insured's Birthdate:_____SSN:_____

Insured's Employer:_____

Insured's Address: _____
Street

_____
City State Zip Code

IN THE EVENT OF AN EMERGENCY, IS THERE SOMEONE WHO LIVES NEAR YOU THAT WE SHOULD CONTACT?

Name:_____

Relationship:_____

Work #:_____HM#:_____

MEDICAL HISTORY

Do you have a physician? Yes ☐ No ☐

Physician's Name:_____

Phone #:_____

Date of last visit:_____

MEDICAL HISTORY continued

YOUR CURRENT PHYSICAL HEALTH IS: Good ☐ Fair ☐ Poor ☐

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

Please explain:_____

Do you use tobacco or controlled substances? Yes ☐ No ☐

Have you ever taken Fosamax, Boniva, Actomel, Fen phen/Redux, or any cancer medications containing bishosphomates?
If YES please provide a complete list. Yes ☐ No ☐

Have you taken Viagra, Revati, Cialis or Levitra in the last 24 hours? Yes ☐ No ☐

Are you taking any prescription or over-the-counter drugs?
If YES please provide a complete list. Yes ☐ No ☐

FOR WOMEN: Are you taking birth control pills? Yes ☐ No ☐

Are you pregnant? Yes ☐ No ☐ Week#:_____

Are you nursing? Yes ☐ No ☐

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL CONDTIONS

Y N Anemia / Radiation Treatment
Y N Angina
Y N Artificial Bones / Joints
Y N Artificial Heart Valves
Y N Asthma
Y N Arthritis
Y N Blood Transfusion
Y N Cancer / Chemotherapy
Y N Cardiac Pacemaker
Y N Chest Pains
Y N Congenital Heart Defect
Y N Diabetes / Tuberculosis (TB)
Y N Difficulty breathing
Y N Drug or Alcohol Abuse
Y N Easily Winded
Y N Emphysema
Y N Epilepsy / Seizures / Fainting
Y N Glaucoma
Y N Fever Blisters / Herpes
Y N Frequently Tired
Y N Heart Attack
Y N Heart Disease / Murmur
Y N Heart Surgery / Pacemaker
Y N Hemophilia / Abnormal Bleeding
Y N Hepatitis
Y N High /Low Blood Pressure
Y N HIV+ / Aids
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Leukemia
Y N Liver Disease
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Rheumatic / Scarlet Fever
Y N Severe / Frequent Headaches
Y N Shingles
Y N Sinus Problems
Y N Stroke
Y N Swollen Ankles
Y N Thyroid Problems
Y N Ulcers / Colitis
Y N Venereal Disease

Are you allergic to any of the following?

Y N Aspirin
Y N Penicillin
Y N Tetracycline
Y N Erythromycin
Y N Barbiturates
Y N Iodine
Y N Local Anesthetics
Y N Latex
Y N Sulfa Drugs
Y N Any Metals

Please provide a complete list of any serious medical conditions or allergies you may have.

DO YOU NEED TO BE PREMEDICATED BEFORE DENTAL TREATMENT? Yes ☐ No ☐

DENTAL HISTORY

Why have you come to the dentist today?_____

_____

Are you currently in pain? Yes ☐ No ☐

Have you ever had a serious / difficult problem associated with any previous dental work? Yes ☐ No ☐

Have you ever had gum disease treatment? Yes ☐ No ☐

Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ /TMD)? Yes ☐ No ☐

Do you like the appearance of your smile, such as the color, shape, and alignment? Yes ☐ No ☐

If you could change anything about your smile what would it be?

_____

Are you concerned about bad breath? Yes ☐ No ☐

Would you like information about professional treatments for breath disorders? Yes ☐ No ☐

Do your gums ever bleed? Yes ☐ No ☐

How many times a week do you floss? _____ a day do you brush?_____

Type of bristles? Hard ☐ Medium ☐ Soft ☐

How long do you use a toothbrush before replacing it? _____

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

_____

Are you currently under the care of an orthodontist? Yes__ No__

If so what is the name of your orthodontist?_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any change in my medical status.

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 accept responsibility for appointments I make and understand I may be charged for no-shows or less than 48 hours notice.

_____

Signature **Date**

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

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help. Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

I authorize Country Club Dental to render treatment for myself or my dependants. I request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants. _____

Signature **Date**

FOR OFFICE USE ONLY **FOR OFFICE USE ONLY** **FOR OFFICE USE ONLY**

Doctor's Comments_____

_____

_____Signature_____ Date:_____

I am currently taking the following medications:

List any other serious medical conditions, allergies or previous surgeries: