modern touch
DENTAL

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

PATIENT INFORMATION

Name _____ Social Security # _____
(Last Name) (First Name) (Middle Initial)

Address _____ City _____ State _____ Zip _____

IMPORTANT:
Home/Main Phone _____ Cell/Other Phone _____ Email _____

Sex ___ M ___ F Age _____ Birthdate _____ ___ Single ___ Married ___ Widowed ___ Separated ___ Divorced

Patient employed by _____ Occupation_____
Business Address _____ Business Phone _____
Business Email _____ Who may we thank for referring you? _____

Notify in case of emergency (name) _____ Home/Main Phone _____
Cell/Other Phone _____ Business Phone _____ Email _____

PRIMARY INSURANCE

Person Responsible For Account _____
(Last Name) (First Name) (Middle Initial)

Relation to Patient _____ Birthdate _____ Social Security # _____
Address (if different from patient) _____ City _____ State _____ Zip _____
Home/Main Phone _____ Cell/Other Phone _____ Email _____

Person Responsible employed by _____ Occupation _____
Business Address _____ Business Phone _____
Business Email _____ Insurance Company _____
Insurance Phone _____ Insurance Email _____
Contract # _____ Group # _____ Subscriber # _____
Name of other dependents under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ___ Y ___ N
Subscriber Name _____ Relation to Patient _____ Birthdate _____
Address (if different from patient) _____ City _____ State _____ Zip _____
Home/Main Phone _____ Cell/Other Phone _____ Email _____

Person Responsible employed by _____ Occupation _____
Business Address _____ Business Phone _____
Business Email _____ Insurance Company _____
Insurance Phone _____ Insurance Email _____
Contract # _____ Group # _____ Subscriber # _____
Name of other dependents under this plan _____

Please complete both sides of this form before returning it to our team.

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

DENTAL HISTORY

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist's Name _____ Address _____
Dentist's Email _____ Phone _____
Date of last dental care appointment _____ Date of last dental x-rays _____

Check (✓) Y (yes) or N (no) if you have had problems with any of the following:

___ Y ___ N Bad breath
___ Y ___ N Food collection between teeth
___ Y ___ N Periodontal treatment
___ Y ___ N Sensitivity to sweets
___ Y ___ N Bleeding gums
___ Y ___ N Grinding or clenching teeth
___ Y ___ N Sensitivity to cold
___ Y ___ N Sensitivity when biting
___ Y ___ N Clicking or popping jaw
___ Y ___ N Loose teeth or broken fillings
___ Y ___ N Sensitivity to hot
___ Y ___ N Sores or growths in mouth

How often do you brush? _____
How often do you floss? _____
How do you feel about the appearance of your teeth? _____
_____
_____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ___ Y ___ N

Other information about your dental health or previous treatment?
_____
_____
_____

MEDICAL HISTORY

Physician's Name _____ Phone _____
Date of last visit _____ Have you had any serious illness or operations? ___ Y ___ N
If yes, please describe _____
Are you currently under physician care? ___ Y ___ N If yes, please describe _____
Have you ever had a blood transfusion? ___ Y ___ N If yes, please give approximate date _____
Have you ever taken Fen-Phen/Redux? ___ Y ___ N Have you ever used a bisphosphonate medication (i.e. Fosamax, Actonel, etc.)? ___ Y ___ N
Women: Are you pregnant? ___ Y ___ N Are you nursing? ___ Y ___ N Are you taking birth control pills? ___ Y ___ N

Check (✓) Y (yes) or N (no) if you have had any of the following:

___ Y ___ N AIDS/HIV Positive
___ Y ___ N Anaphylaxis
___ Y ___ N Anemia
___ Y ___ N Arthritis, Rheumatism
___ Y ___ N Artificial heart valves
___ Y ___ N Artificial joints
___ Y ___ N Asthma
___ Y ___ N Atopic (allergy prone)
___ Y ___ N Back problems
___ Y ___ N Blood disease
___ Y ___ N Cancer
___ Y ___ N Chemical dependency
___ Y ___ N Chemotherapy
___ Y ___ N Circulatory problems
___ Y ___ N Cortisone treatments
___ Y ___ N Cough, persistent
___ Y ___ N Cough up blood
___ Y ___ N Diabetes
___ Y ___ N Epilepsy
___ Y ___ N Fainting
___ Y ___ N Food allergies
___ Y ___ N Glaucoma
___ Y ___ N Headaches
___ Y ___ N Heart murmur
___ Y ___ N Heart problems
___ Y ___ N Hemophilia/ Abnormal bleeding
___ Y ___ N Herpes
___ Y ___ N Hepatitis
___ Y ___ N High blood pressure
___ Y ___ N Jaw pain
___ Y ___ N Kidney disease or malfunction
___ Y ___ N Liver disease
___ Y ___ N Material allergies (**latex**, wool, metal, chemicals)
___ Y ___ N Mitral valve prolapse
___ Y ___ N Nervous problems
___ Y ___ N Pacemaker/ Heart Surgery
___ Y ___ N Psychiatric care
___ Y ___ N Rapid weight loss/gain
___ Y ___ N Radiation treatment
___ Y ___ N Respiratory disease
___ Y ___ N Rheumatic/Scarlet fever
___ Y ___ N Shingles
___ Y ___ N Shortness of breath
___ Y ___ N Skin rash
___ Y ___ N Spina bifida
___ Y ___ N Stroke
___ Y ___ N Surgical implant
___ Y ___ N Swelling of feet or ankles
___ Y ___ N Thyroid disease or malfunction
___ Y ___ N Tobacco habit
___ Y ___ N Tonsillitis
___ Y ___ N Tuberculosis
___ Y ___ N Ulcer/Colitis
___ Y ___ N Venereal disease

Is patient currently taking any medications? ___ Y ___ N If yes, list all: _____
Does patient have drug allergies? ___ Y ___ N If yes, list all: _____

AUTHORIZATION

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine the appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. · I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. · I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not they are paid by insurance.

Signature _____ **Date** _____

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