Today's Date ____________________

Chart Number ____________________

www.DentFirst.com

PATIENT INFORMATION

(Please Print)

First Name & Middle Initial ______________________

Last Name ______________________

Street Address ______________________

City ______________ State_____ Zip ________

Check Your Best Contact #
- ☐ Home Phone ______________
- ☐ Work Phone ______________
- ☐ Cell Phone ______________

If we cannot reach you by phone, we may text you unless you opt out by checking this box ☐

SSN# ______________________

Date of Birth (MM/DD/YY) ____________ Age ______

Marital Status: Single Married Gender: Male Female

E-Mail Address ______________________

DentFirst uses your email address to send e-statements, offer online payments and online appointment scheduling.

☐ Check here to receive only mailed paper statements.*

Employer ______________________

POLICY HOLDER INFORMATION

Same as Patient ☐ if not, Spouse Child Other __________

First Name & Middle Initial ______________________

Last Name ______________________

Street Address ______________________

City ______________ State______ Zip ________

Check Your Best Contact #
- ☐ Home Phone ______________
- ☐ Work Phone ______________
- ☐ Cell Phone ______________

If we cannot reach you by phone, we may text you unless you opt out by checking this box ☐

SSN# ______________________

Date of Birth (MM/DD/YY) ____________ Age ______

Marital Status: Single Married Gender: Male Female

E-Mail Address ______________________

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Employer ______________________

INSURANCE INFORMATION

Primary Dental Insurance Co ______________________ Group # __________ Phone # ____________

Policy Holder's Name ______________________ ID/Policy# ____________

Secondary Dental Insurance Co ______________________ Group # __________ Phone # ____________

Policy Holder's Name ______________________ ID/Policy# ____________

Medical Insurance Company ______________________ Group # __________ Phone # ____________

Policy Holder's Name ______________________ ID/Policy# ____________

IN CASE OF AN EMERGENCY, LIST YOUR NEAREST RELATIVE OR FRIEND **NOT LIVING WITH YOU**:

Name ______________________ Phone ______________ Relationship ____________

Whom may we thank for referring you to our office?

Friend/Family ______________________ Doctor/ER/Urgent Care ______________________

Insurance ____ Sign ____ Website ____ Coupon/Flyer____ YP ____ Social Media __________Other: ______________

I, the undersigned (patient or legally responsible party) authorize treatment to be rendered and assume financial responsibility. I also authorize release of any information relating to my insurance claims and the assignment of any and all insurance benefits directly to DentFirst, P.C. I acknowledge that all non-current balances on accounts over sixty days will be charged a service fee of 1.75% per month (21% annually) on the unpaid balance and that my credit information may be accessed. At this time any professional courtesy and/or budget account balances may be added back to the account. Any additional costs incurred in collecting this account, including court and attorney fees, will be added to my balance due. Inactive accounts may be accessed an administrative fee. *Past due statements sent via postal mail incur a $5 printing and postage fee. I acknowledge receipt of DentFirst's 'Notice of Privacy Practices' attached. I understand that the dentists at DentFirst are independent contractors and have full authority, responsibility, and control over their work.

SIGNATURE OF PERSON RESPONSIBLE FOR THE PAYMENT OF THE ACCOUNT: ______________________

PLEASE CONTINUE TO NEXT SHEET- MEDICAL HISTORY FORM

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. When did you last receive dental treatment? _____________
   What type of treatment? ____________________________
2. Previous Dentist ____________________________________
   City, State ____
3. Do you have dentures, partial dentures, bridges or crowns?
   If yes, when were they made? _______________ Y N
4. Date of last physical examination ______________________
5. Have you been hospitalized during the past three years? Y N
6. Have you had any serious illnesses in the past three years?
   If so, please explain. ______________________ Y N
7. Are you under a physician's care? Y N
   If yes, for what condition? ___________________________
8. Have you ever worn braces? Y N
9. Have you ever had gum surgery? Y N
10. Have you ever had any difficulty with any dental work or extractions? Y N
11. Have you ever had any surgical prostheses? Y* N
    (Joint replacements or implants)
12. I prefer tooth-colored fillings rather than silver/amalgam/mercury fillings on my back teeth. I understand that my insurance company may only pay towards the cheaper fillings and I will be responsible for the difference in fees, if any. Y N
13. I am happy with the color of my teeth Y N
14. Do you snore or been told you snore? Y N
15. Have you ever been diagnosed with sleep apnea? Y N
16. Have you been prescribed the use of a CPAP? Y N

Do you have or have you had any of the following conditions or diseases?

CARDIOVASCULAR

20.	Rheumatic Fever	Y	N
21.	Congenital Heart Defect	Y*	N
22.	Angina or Heart Attack	Y	N
23.	Heart Murmurs	Y	N
24.	Congestive Heart Failure	Y	N
25.	Heart Surgery or Pacemaker	Y*	N
26.	(High) or (Low) Blood Pressure (Circle One)	Y	N
27.	Stroke	Y	N

RESPIRATORY DISEASE

30.	Asthma, Bronchitis or Emphysema	Y	N
31.	Hay Fever or Sinusitis	Y	N

ENDOCRINE DISORDERS

40.	Diabetes	Y	N
41.	(Hyperthyroidism) or (Hypothyroidism)(Circle One)	Y	N

BLOOD DISORDERS

50.	Anemia	Y	N
51.	Do you bleed excessively when cut?	Y	N

KIDNEY DISEASE

60.	Have you had any kidney infections or surgery?	Y	N

INFECTIOUS DISEASES

70.	Hepatitis	Y	N
71.	Venereal Disease (Within the last 10 years)	Y	N
72.	Tuberculosis	Y	N
73.	HIV Positive	Y	N

____

DOCTOR'S SIGNATURE **DATE**

____
Chart#

MISCELLANEOUS DISEASES AND DISORDERS

80.	Frequent Fainting	Y	N
81.	Liver Disease	Y	N
82.	Arthritis	Y	N
83.	Ulcers	Y	N
84.	Glaucoma	Y	N
85.	Radiation Therapy for Cancer	Y	N
86.	Epilepsy	Y	N
87.	Cancer	Y	N
88.	Do you smoke or use any other form of tobacco?	Y	N

Are you currently taking any of the following drugs or medications?

90.	Antibiotics	Y	N
91.	Blood Thinners	Y	N
92.	Steroids or Cortisone	Y	N
93.	High Blood Pressure Medicine	Y	N
94.	Tranquilizers	Y	N
95.	Aspirin	Y	N

Please list all of the prescribed medications you are currently taking:

____
____
____

Do you have an ALLERGY or reaction to any of the following medications?

100.	Local Anesthetics	Y	N
101.	Penicillin	Y	N
102.	Other Antibiotics	Y	N
103.	Codeine	Y	N
104.	Aspirin or Other Pain Medication	Y	N
105.	Latex	Y	N
106.	Barbiturates or Sedatives	Y	N
107.	Other Medicines or Materials?	Y	N
	If yes, please list. ______________________		

Do you have any medical problem not listed above? If yes, please explain. ______________________ Y N

____

110. Are you pregnant? Y N
     If yes, when are you due? _______________

* If you answer 'Y' to any of the starred questions, current American Heart Association standards may require that you take antibiotics immediately before each dental appointment. If you fail to do so we may be required to reschedule your appointment unless we receive a written exemption from a physician.

____
PATIENT'S SIGNATURE **DATE**
(Parents must sign for their minor children)

PATIENT'S INITIALS FOR UPDATE: **DATE:**
(Parents must sign for their minor children)

______________________ __________
______________________ __________
______________________ __________