CLARK FAMILY
dentistry

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Patient Information

Date: ____________

Name: ______________________________ Date of Birth: ______________

Home Phone: ______________ Cell Phone: ______________ SS #: ______________

Email Address: ______________________

Address: ______________ City: ______________ ST: ______ Zip: ______________

Check Appropriate Boxes: ❑ Minor ❑ Single ❑ Married ❑ Male ❑ Female

Employer: ______________ Occupation: ______________ Work Phone: ______________

Spouse/Parent's Name: ______________ Employer: ______________ Work Phone: ______________

Person To Contact In Case Of Emergency: ______________ Phone: ______________

Whom May We Thank For Referring You? ❑ Telephone Book ❑ Social Media

❑ Word of Mouth (please list)____________ ❑ Other (please list)____________ ❑ Radio

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Responsible Party

Name Of Person Responsible For This Account: ______________ Relationship To Patient: ________

Date Of Birth: ______________ Home Phone: ______________ Work Phone: ______________

Address: ______________ City: ______________ ST:______ Zip: ______________

Employer: ______________________________ SS #: ______________

Payment in full is expected at each appointment

Dental Insurance Information

Does patient have insurance? ❑ Yes ❑ No

Name Of Insured: ______________________________ Relationship To Patient: ________

Date Of Birth: ______________ SS #: ______________

Name Of Employer: ______________________________ Work Phone: ______________

Employer Address: ______________ City: ______________ ST: ______ Zip: ______________

Insurance Company: ______________ Group #: ______________ Policy/ID #: ______________

Insurance Co. Address: ______________ City: ______________ ST: ______ Zip: ______________

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ❑ Yes ❑ No **IF YES, COMPLETE THE FOLLOWING**

Name Of Insured: ______________________________ Relationship To Patient: ________

Date Of Birth: ______________ SS #: ______________

Name Of Employer: ______________________________ Work Phone: ______________

Employer Address: ______________ City: ______________ ST: ______ Zip: ______________

Insurance Company: ______________ Group #: ______________ Policy/ID #: ______________

Insurance Co. Address: ______________ City: ______________ ST: ______ Zip: ______________

Medical History

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY YOU WILL RECEIVE. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

Are you under a physician's care now? ❑ Yes ❑ No ❑ N/A ____________

Have you ever been hospitalized or had a major operation? ❑ Yes ❑ No ❑ N/A ____________

Have you ever had a serious head or neck injury? ❑ Yes ❑ No ❑ N/A ____________

Are you taking any medications, pills or drugs? Please list. ❑ Yes ❑ No ❑ N/A ____________

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Do you use tobacco? ❑ Yes ❑ No ❑ N/A ____________

Do you use controlled substances? ❑ Yes ❑ No ❑ N/A ____________

Have you ever had complications or illness following dental work done? ❑ Yes ❑ No ❑ N/A ____________

Are you nervous or concerned about having dental work done? ❑ Yes ❑ No ❑ N/A ____________

Women: Are you ❑ Pregnant ❑ Nursing

❑ Taking oral contraceptives?

Are you allergic to any of the following? ❑ No

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetics ❑ Other ________

Do you have, or have you had, any of the following? ❑ No

❑ AIDS / HIV Positive
❑ Angina / Chest Pains
❑ Artificial Heart Valve
❑ Artificial Joints
❑ Asthma / Emphysema
❑ Blood Disease
❑ Bruise Easily
❑ Cancer
❑ Canker Sores
❑ Chemotherapy
❑ Cold Sores
❑ Congenital Heart Disorder
❑ Diabetes
❑ Drug addiction
❑ Epilepsy / Seizures
❑ Glaucoma
❑ Headaches
❑ Heart Attack / Heart Failure / Disease
❑ Heart Murmur
❑ Heart Pace Maker
❑ Heart Surgery
❑ Hemophilia / Anemia
❑ Hepatitis A
❑ Hepatitis B or C
❑ High Blood Pressure
❑ Hypoglycemia
❑ Kidney Problems
❑ Liver Disease
❑ Low Blood Pressure
❑ Pain in Jaw Joints
❑ Radiation Therapy
❑ Renal Dialysis
❑ Rheumatic Fever
❑ Scarlet Fever
❑ Shortness of Breath
❑ Sleep Apnea
❑ Snoring
❑ Stomach / Intestinal Disease
❑ Stroke
❑ Thyroid Disease
❑ Tuberculosis

Have you ever had any serious illness not listed above? ❑ Yes ❑ No ❑ N/A ____________

Dental Treatment Desired (please circle all that apply): Checkup Cleaning Cavities Restored

Missing Teeth replaced Teeth Extracted Sleep Apnea / Snoring Treatment Dental Implants

Orthodontics Complete Dentures/ Partials Other____________

Is there anything you don't like about your teeth? ____________

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payor and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill of services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is expected at the time of service.

X____________________________ Date ____________