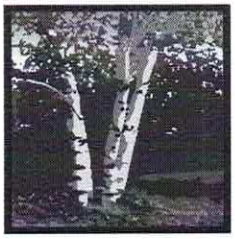

Welcome to Professional Dental Group

From whom did you hear about our office? _____

May we mention your name when thanking them?_____

NAME:_____Name preferred:_____ Sex: □**M** □**F**

Birthdate:_____/_____/_____ Social Security #: _____ Marital Status: □ S □ M □ D □ W

Phone:_____ Cell Phone:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Email:_____

Employed by:_____ Work phone:_____

SPOUSE:_____Birthday:_____/_____/_____ Cell phone:_____

Employed by:_____ Work phone:_____

Emergency Contact Person:_____Phone:_____

Relationship to Patient:_____Cell Phone:_____

IF PATIENT IS A CHILD/DEPENDENT

Parent/Guardian:_____Birthdate:____/____/____ Cell phone:_____

Employed by:_____ Work phone:_____

Parent/Guardian: _____Birthdate:____/____/____Cell Phone:_____

Employed by:_____ Work phone:_____

INSURANCE INFORMATION

Dental Insurance Company: _____ Insurance Phone #: _____

Group #:_____ ID #:_____

Name of Policy Holder:_____ Policy Holder's Date of Birth: _____

Employer:_____

**Please note if you have Delta Dental for insurance make sure to designate from which state _____

HIPAA AUTHORIZATION (Patients 18yrs or older)

I give Professional Dental Group consent to share/discuss the information listed below with the following individual(s):

Name(s)/Relationship: _____

Please check one of the following options for which information you are consenting for us to share/discuss:

□ My complete dental record, billing and appointments

□ Limited information, only disclose the following checked options:

□ Dental/Chart records □ Billing □ Appointments

ASSIGNMENT & RELEASE: I hereby authorize my insurance benefit payments to be assigned directly to Professional Dental Group. I also authorize the dentist to release any information required for the insurance claim.

FINANCIAL AGREEMENT: By signing I understand and accept that payment in full is due at the time of service, unless discussed and accepted by this office prior to services being provided. If there is dental insurance, we will **estimate** any co-payments or payments that will be due at the time of service. This is NOT a guarantee of benefits. Because of the number of patients and insurance plans, we are unable to know the specifics of your plan. We encourage you to become familiar with your own plan. You are responsible for any balances that remain on your account if the insurance does not pay as much as anticipated or they deny payment.

CANCELLATION/RESCHEDULE AND NO-SHOW POLICY: By signing I understand and accept that an appointment that is not cancelled/rescheduled at least 24 hours in advance or is a no-show will incur a $75 fee. To ensure we receive any cancellation/reschedule requests, please call our office (we cannot accept them via email or text). If a patient is more than 10 minutes late for their scheduled appointment, we may need to reschedule and the cancellation fee may apply. It is important to note that this fee is not covered by your insurance.

THANK YOU for choosing PROFESSIONAL DENTAL GROUP. Our goal is to offer you the best possible dental care and understanding of the dental treatment recommended to you.

SIGNATURE:_____ DATE:_____

Printed Name:_____
(If patient is a minor, the name of Parent/Guardian completing and signing this form)

Please proceed to the next page to complete the health and dental history.

HEALTH HISTORY

Name: _____ Birthdate: _____

Physician/Clinic:_____ Office Phone:_____ Last physical exam:_____

YES NO

☐ ☐ 1. Are you taking any prescribed medication(s) Or any non-prescription drugs (i.e. vitamins)? If yes, please list:

_____

_____

_____

☐ ☐ 2. Do you use tobacco? Kind? _____

3. Are you allergic to or have you ever reacted to:

☐ ☐ • Local Anesthetics (e.g. Novacaine)?
☐ ☐ • Penicillin or other antibiotics?
☐ ☐ • Sulfa drugs?
☐ ☐ • Latex?
☐ ☐ • Aspirin or Codeine?
☐ ☐ • Metals (e.g. nickel)?
☐ ☐ • Other _____

☐ ☐ 4. Are you pregnant? Or think you might be?

☐ ☐ 5. Are you on birth control or hormone replacements?

4. Carefully read the following and **CHECK** any that have ever affected you and circle if a choice:

☐ High/Low blood pressure
☐ Heart attack-date_____
☐ Heart disease
☐ Blood thinner
☐ Cardiac pacemaker
☐ Heart murmur
☐ AIDS or HIV infection
☐ Fainting
☐ Seizures/Epilepsy
☐ Kidney disease
☐ Liver disease
☐ Thyroid problems
☐ Ulcers/stomach problems
☐ Respiratory problems
☐ Asthma
☐ Rheumatic fever
☐ Glaucoma
☐ Diabetes
☐ Arthritis
☐ Heart Valve Replacement
☐ Artificial joint/limbs
Type_____Date_____

☐ Cancer/Type_____Date_____
☐ Radiation/chemotherapy
☐ Tuberculosis
☐ Stroke
☐ Sleep apnea/snoring
CPAP/Oral Sleep appliance
☐ Pins/Plates – Date_____
☐ Hepatitis
☐ Herpes
☐ Chemical dependency
☐ Recreational drug use
☐ Loss of hearing
☐ Recent weight loss/gain
☐ Eating disorders
☐ Allergies/seasonal
☐ Anemia
☐ Memory Issues/Dementia
☐ Acid Reflux
☐ High Cholesterol
☐ Other: _____

DENTAL HISTORY

Last dental visit? _____ For: ☐ Exam ☐ Cleaning ☐ Toothache ☐ Other_____

How do you feel about going to the dental office? ☐ Fine ☐ Slightly nervous ☐ Very uncomfortable

YES NO

☐ ☐ 1. Do your gums bleed while brushing?
☐ ☐ 2. Are your teeth sensitive?
☐ ☐ 3. Do you feel pain to any teeth?
☐ ☐ 4. Have you had any head, neck or jaw injuries?
☐ ☐ 5. Do you grind or clench your teeth?
☐ ☐ 6. Have you ever been told you have TMJ?
☐ ☐ 7. Have you ever had any prolonged bleeding following dental extractions?

YES NO

☐ ☐ 8. Have you ever had braces/orthodontic work?
☐ ☐ 9. Have you ever been told you have gum disease?
☐ ☐ 10. Have you had periodontal treatment?
☐ ☐ 11. Do you wear a Nightguard?
☐ ☐ 12.Do you have dental implants
☐ ☐ 13. Any other dental concerns:_____

_____

_____

SIGNATURE:_____ Date:_____

Comments: