

# WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet your entire 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!

Date \_\_\_\_\_

## Personal Information

Name \_\_\_\_\_ Wishes To Be Called \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

Male \_\_\_ Female \_\_\_

Minor \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Separated \_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Referred To Our Office By: \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext.# \_\_\_\_\_

Cell Phone \_\_\_\_\_ Pager \_\_\_\_\_

Where do you prefer to receive calls? \_\_\_ Home \_\_\_ Work \_\_\_ Cell

When is the best time to reach you? Time \_\_\_\_\_ Days \_\_\_\_\_

## Responsible Party

Who is responsible for the account?

Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_

Driver's License # \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Home Phone \_\_\_\_\_

## Emergency Contact

In the event of an emergency, who should we contact?

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Work # \_\_\_\_\_ Home # \_\_\_\_\_

## **Dental Insurance Information**

### **Primary Insurance**

Name of Insured \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insured's Birthdate \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Ins. Co. Phone # \_\_\_\_\_

### **Secondary**

Name of Insured \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insured's Birthdate \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Ins. Co. Phone # \_\_\_\_\_

## **Authorization and Release**

- I acknowledge that I am financially responsible for payment of all services rendered on my behalf or my dependents.
- If I am insured, I understand that my dental insurance carrier may pay less than the actual bill for services and that I am responsible for the difference.
- If it becomes necessary to effect collections of any amount owed on this or subsequent visits the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees.
- I hereby authorize the doctor to release information necessary to secure payment of benefits.
- I authorize and request my Insurance Co. to pay directly to the dentist, insurance benefits otherwise payable to me.
- I authorize Dr. da Costa to use my Social Security Number as my dental record insurance ID number.
- I give permission for Dr. da Costa's office to leave telephone messages for myself or family members.
- I authorize the release of information from my dental records to be released to and reviewed by employees of my insurance company, their agents or my dental care providers while I am receiving care or after discharge.
- If I have been referred or choose to go to another dental provider, I authorize Dr. da Costa's office to release a copy of my dental records to that Doctor for the purpose of providing care.
- In our office before and after photographs are often taken for documentation. Your photos may be selected for public viewing. Your name will not be mentioned nor will royalties be collected. I authorize Dr. da Costa to use my photos for educational purposes.

**I certify the information given by me is correct and I have read and consent to the terms of the financial agreement. I am the patient, or I am authorized as the patient's agent or representative to execute the above and accept its terms on behalf of the patient, or I assume individually all financial responsibility by signing below.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

## DENTAL AND MEDICAL BACKGROUND

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Spouse: \_\_\_\_\_ Work Phone: \_\_\_\_\_

In case of emergency, person to contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Date of last visit: \_\_\_\_\_

Reason for that visit: \_\_\_\_\_

Please take your time in filling out your dental and medical background. The following information is essential for our office to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to meet your dental needs safely and efficiently. Incomplete or incorrect information could be dangerous to your health.

### DENTAL HISTORY

When was your last dental visit? \_\_\_\_\_

Reason for that visit? \_\_\_\_\_

Date your last full mouth set of X-rays were taken (18-22 picture series): \_\_\_\_\_

Name, address, and phone number of dentist where last full mouth X-rays were taken: \_\_\_\_\_

What brings you to our dental office today? \_\_\_\_\_

Would you like your smile to look better or different? \_\_\_\_\_

How? \_\_\_\_\_

What would you change about your smile if you could? \_\_\_\_\_

Would you like your teeth to be whiter? \_\_\_\_\_

Generally, how do you feel about visiting the dentist? Rate on scale from 1-5.

1 - completely relaxed to 5-extremely nervous (Please check one.) 1 2 3 4 5

Please rank the following in the order in which they would keep you from having dental treatment:

Fear of pain \_\_\_\_\_ Lack of concern \_\_\_\_\_

Cost of treatment \_\_\_\_\_ Missing work time \_\_\_\_\_

Y / N

Do your teeth affect your general health? .....

Are you having any dental discomfort right now? .....

Have you ever been treated for periodontal disease .....

(Gum disease, pyorrhea, trench mouth) Date \_\_\_\_\_ (year)

Describe your dental health:    Good            Fair            Needs Improvement

### How often to you use the following?

Toothbrush: \_\_\_\_\_ Toothpick: \_\_\_\_\_

Floss: \_\_\_\_\_ Other: \_\_\_\_\_

Fluoride Rinse: \_\_\_\_\_

**Do you have or have you had in the last 5 years any of the following?**

**MOUTH**

- Bleeding sore gums .....
- Unpleasant taste/bad breath .....
- Burning tongue/lips .....
- Frequent blisters, lips/mouth .....
- Swelling/lumps in mouth .....
- Ortho, treatment (braces) .....
- Habit of biting cheeks/lips .....
- Clicking/popping jaw .....
- Difficulty opening/closing jaw .....

**Y / N TEETH**

- Loose teeth .....
- Sensitivity to hot .....
- Sensitivity to cold .....
- Sensitivity to sweets .....
- Sensitivity to biting .....
- Food impaction areas .....
- Clinching/grinding habits .....
- If so, when: \_\_\_\_\_
- Shifting/ changes in your bite .....

**Y / N**

**MEDICAL HISTORY**

Are you in good health now? \_\_\_\_\_

Are you now or in the last 5 years been under the care of a physician? \_\_\_\_\_

If so, what is the condition being treated? \_\_\_\_\_

Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously? \_\_\_\_\_

Do you use tobacco in any form? Y N If yes, which form and how much? \_\_\_\_\_

Do you drink alcoholic beverages (more than two drinks per day)? \_\_\_\_\_

Are you a recovering alcoholic? \_\_\_\_\_

(Women) Are you pregnant? Y N If so, please give due date: \_\_\_\_\_

Are you ALLERGIC or have you ever experienced any reaction to the following?: **Y / N**

Local anesthetics (novocaine) .....

Barbiturates/sedatives/sleeping pills .....

Penicillin / other antibiotics .....

Aspirin or Codeine .....

Sulfa drugs .....

Latex .....

Other allergies .....

Do Drugs make you nauseated? If so, which ones? \_\_\_\_\_

**Are you taking any of the following:** Y / N

Antibiotics/ Sulfa drugs .....

Blood thinners .....

Blood pressure medication .....

Thyroid medicine .....

Cortisone/Steroids .....

Antihistamine/Allergy Drugs/

Cold Remedies .....

Have your ever take Phen-Phen? .....

or Redux? .....

If yes to any of the above, list name of medication, dosage and condition for which you are taking it:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Tranquilizers

Insulin/other diabetes medications .....

Digitalis/other heart medications .....

Nitroglycerin .....

Aspirin .....

Any over the counter medicines .....

**Y / N**

Do you have or have you had in the last 5 years any of the following?

**GENERAL**

Tire easily, weakness .....  
 Marked weight change .....  
 Night sweats.....  
 Persistent fever.....

Y / N **NOSE**

Frequent nosebleeds .....  
 Sinus problems .....

Y / N

**SKIN**

Eruptions (rash) hives.....  
 Change in skin color.....  
 Cold sores.....

Y / N

**THROAT**

Soreness/Hoarseness.....

Y / N

**EYES**

Visual change.....

Y / N

**NERVOUS SYSTEM**

Stroke.....  
 Headaches.....  
 Head Injury.....  
 Convulsions/Epilepsy.....  
 Numbness/Tingling.....  
 Dizziness/Fainting.....  
 Psychiatric treatment.....

Y / N

**EARS**

Loss of hearing.....  
 Ringing in ears.....

Y / N

**RESPIRATORY**

Tuberculosis.....  
 Emphysema.....  
 Asthma.....  
 Hay Fever.....  
 Persistent cough.....  
 Sputum production (phlegm).....  
 Bloody sputum.....  
 Difficulty breathing while lying down.....

Y / N

**BONE/MUSCLES**

Arthritis/Rheumatism.....  
 Artificial joint.....  
 Which one? \_\_\_\_\_

Y / N

**DIGESTIVE SYSTEM**

(Check One)

Hepatitis..... Type: A B C.....  
 Jaundice.....  
 Ulcers.....  
 Change in appetite.....  
 Stomach or Bowel.....

Y / N

**ENDOCRINE**

Diabetes.....  
 Family history of diabetes.....  
 Thyroid condition/Goiter.....  
 Other: \_\_\_\_\_

Y / N

**URINARY**

Kidney disease.....  
 Kidney Dialysis.....  
 Increase in frequency of urination (night).....  
 Burning on urination.....  
 Urethral discharge.....  
 Bloody urine.....  
 Venereal disease.....

Y / N

**HEART/BLOOD VESSELS**

Rheumatic fever.....  
 Heart murmur.....  
 If yes, last diagnosed: \_\_\_\_\_  
 Chest pain/discomfort.....  
 Heart condition.....  
 Heart attack.....  
 Date: \_\_\_\_\_  
 Swelling of ankles.....  
 High blood pressure.....  
 Congenital heart disease.....  
 Artificial heart valve.....  
 Pacemaker.....  
 Heart surgery.....  
 Mitral valve prolapse.....  
 Other: \_\_\_\_\_

Y / N

**BLOOD**

Frequent Bruises.....  
 Anemia.....  
 Blood Transfusion.....  
 Date: \_\_\_\_\_  
 Bleeding Disorder.....

Y / N

**OTHER**

Immune system disorders  
 (AIDS, HIV, ARC).....  
 Radiation therapy.....  
 Tumors or growths.....  
 Cancer.....  
 Date: \_\_\_\_\_  
 Types of treatment \_\_\_\_\_

Y / N

If so, what type? \_\_\_\_\_

Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, please explain: \_\_\_\_\_

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of person completing form if other than patient \_\_\_\_\_