

Patient Information

_____	_____	_____	_____
Patient Last Name	Patient First Name	Preferred Name (If any)	Date of Birth
_____	_____	_____	_____
Social Security #	Drivers License	Employer Name	Occupation
_____	_____	_____	_____
Address	City	State	Zip Code
_____	_____	_____	_____
Cell Phone	Home Phone	Work/Other	
_____	_____	_____	
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Child			
E-Mail Address _____			
How did you hear about us? _____			

EMERGENCY CONTACT INFORMATION

_____	_____
Emergency Contact Name	Relationship
_____	_____
Cell Phone	Home Phone
_____	Work/Other
_____	_____

Parent/Legal Guardian Information (If patient is minor)

Parent's marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Single		Relation: _____
_____	_____	
Parent Full Name	Date of Birth	
_____	_____	
Address (If different than above)	City	State Zip Code
_____	_____	_____
<input type="checkbox"/> Male <input type="checkbox"/> Female		
E-Mail Address _____		

Insurance Information

_____	_____	_____
Subscriber's Name	Subscriber Date of Birth	Subscriber ID/SSN#
_____	_____	_____
Employer Name _____		
_____	_____	
Insurance Address	Insurance Phone Number	
Patient Relation to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____		

As a policy, financial arrangements must be made prior to your treatment. All dental emergency services must be paid in full, if insurance company cannot be contacted at the time of services. **Authorization and Release:** I authorize and request my insurance company to pay, Pearl Shine Dental, the insurance benefits. I authorize Pearl Shine Dental to release all information necessary to secure payment of benefits. **I understand that the treatment plan I receive is only an estimate and that I am financially responsible for any unpaid balances that the insurance does not pay.**

Patient and/or Legal Guardian/Parent Signature

Date

Reason for today's visit: _____

Name of Previous Dentist: _____ Date of your last dental visit: _____

Have you had complications following dental treatment? Y N

If yes please explain: _____

Would you change anything about the appearance of your teeth? Y N

If yes please explain: _____

Do you smoke or chew tobacco Y N Do you use Alcohol Y N

Do you have any of the following dental condition?

Bad Breath Y N Sore or Growth Y N Sensitive to hot cold or biting Y N

Bleeding Gums Y N Clicking or Popping jaw Y N Periodontal Treatment Y N

Grinding Teeth Y N Loose teeth or broken filling Y N Food caught between teeth Y N

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

Allergies Y N Liver Disease Hepatitis A, B, C/ Jaundice Y N

Congenital Heart Disease Y N Kidney Disease Y N

Cardiovascular Disease Y N Diabetes Y N

High/ Low Blood Pressure Y N Thyroid Disease Y N

Heart Murmur/ Mitral Valve Prolapse Y N Stomach Ulcer/ Colitis Y N

Heart Attack / Angina Y N Arthritis Y N

Stroke Y N Glaucoma Y N

Pacemaker Y N Artificial Heart Valve Y N

Heart Surgery Y N Artificial Joint (Hip/ Knee) Y N

Rheumatic Fever/ Rheumatic Heart Disease Y N HIV/ AIDS Y N

Respiratory Disease Y N STD (Sexually Transmitted Disease) Y N

Asthma Y N Radiation/ Chemotherapy for Cancer Y N

Emphysema Y N Bleeding Disorder/ Anemia/ Blood Transfusion Y N

Pneumonia Y N Seizures/ Epilepsy/ Fainting/ Psychiatric Treatment Y N

Tuberculosis Y N Dizziness/ Nervous Disorder Y N

Shortness of Breath Y N Any Disease, Drugs, or Transplant operation that Y N

Chest Pain Y N has depressed your Immune System Y N

Physician's name: _____ Phone number: _____

Are you under Physician's care?

If yes, explain: _____

Women: Are you pregnant? Y N Are you Breast feeding? Y N Are you taking Birth Control Pills? Y N

Have you been hospitalized or needed emergency care in the past two years? Y N

If yes explain: _____

List of any Medications: (If none put "NONE")

Are you allergic (if none put "none") to: Penicillin Codeine Latex Iodine Sulfa Other _____

I understand that honest answers to the questions stated below are important to the provision of my dental care, and that I will answers them best of my ability. I have been informed that if I am uncertain about the question or how the question relates to my health status I must discuss the problem with the doctor or a member of the staff. I understand that all questions must be answered. I have been assured that the information I provide will not be released without my express permission. To the Best of my knowledge, all of the following information is correct and true.

I understand that should there be a change in my health during my dental treatment, I am to inform the dentist at the earliest possible time.

Patient/ Guardian/ Parent Signature

Date

Doctor's Initials