Augusta DENTAL

Insurance Information

Relation to policy holder: ◯Self ◯Spouse ◯Child

Dental **Insurance- 1st Coverage**

Policy Holder_____

Policy Holder Date of Birth _____

Name of Insurance Co. _____

Address _____

Telephone _____

I.D or policy # _____

Group # _____

Dental Insurance- 2nd Coverage

Policy Holder_____

Policy Holder Date of Birth _____

Name of Insurance Co. _____

Address _____

Telephone _____

I.D or policy # _____

Group # _____

Patient Information

First Name: _____ M.I._____

Last Name:_____

Preferred Name:_____

Sex: ◯ F ◯M Date of Birth:_____/_____/_____

SS#_____

Driver's Lic.#_____

Email: _____

Address_____

City:_____ State:_____ Zip:_____

Hm # (_____)_____-_____

Wk # (_____)_____-_____Ext._____

Cell (_____)_____-_____

Patient/Parent Employer_____

Present Position:_____

Referred by: ◯Phonebook ◯Website ◯Location ◯ Other

◯Patient _____

In case of emergency who should be notified?

_____ Phone: _____

Responsible Party

Who will be responsible for the account? ◯Self (if self you don't need to fill out this section) ◯ Father ◯ Mother ◯Other_____

Name:_____ Soc. Sec. # _____ D.L.#_____

Date of Birth__'____/_____/_____Hm Tel.# (_____)_____-_____Cell # (_____)_____-_____

Address:_____ City:_____ State:_____ Zip_____

Employer:_____Tel.:(_____)_____-_____

Smile Evaluation

Do you like the appearance of your teeth?	◯	**Yes**	◯	**No**	Do you smoke or chew?	◯	**Yes**	◯ **No**
If no, please explain					Are your teeth all in alignment (straight)?	◯	**Yes**	◯ **No**
Do you have dental examinations on routine basis?	◯	**Yes**	◯	**No**	Do you have spaces you don't like?	◯	**Yes**	◯ **No**
Are there old fillings or dental work you don't like looking at?	◯	**Yes**	◯	**No**	Do you like the color of your teeth?	◯	**Yes**	◯ **No**
Do you ever have clicking/popping/discomfort in the jaw joint?	◯	**Yes**	◯	**No**	Do you snore?	◯	**Yes**	◯ **No**
Do you clinch or grind your teeth?	◯	**Yes**	◯	**No**	Do you brush and floss daily?	◯	**Yes**	◯ **No**
Have your past dental experiences been positive	◯	**Yes**	◯	**No**	Do your gums ever bleed?	◯	**Yes**	◯ **No**
Do you have specific dental problems?	◯	**Yes**	◯	**No**	Have you ever been treated for gum disease?	◯	**Yes**	◯ **No**
When was the last full mouth series of x-rays taken?					When is the last time you had your teeth cleaned?			
Name of previous dentist:								

Patient Name:_____ **D.O.B.:**_____

Medical Information

Reason for today's office visit:

_____

Name of your Physician:

_____

Phone:_____

Have you had any illness, operation or been hospitalized in the past five years?

_____

_____

Are you taking any medication? Y ◯ N ◯

Please List

_____

_____

_____

_____

Are you allergic to any medications or substances?

◯ Latex ◯ Penicillin ◯ Codeine ◯ Sulfa

◯ Aspirin ◯ Acrylic ◯ Metal

◯ Other_____

Women

Pregnant/trying to get pregnant Y ◯ N ◯

Nursing Y ◯ N ◯

Taking oral contraceptives Y ◯ N ◯

Health History

Heart Trouble/Disease	Yes	No	Irregular Heart Beat	Yes	No
Angina/ Chest Pain	Yes	No	Heart Attack/ Failure	Yes	No
Congenital Heart Disorder	Yes	No	Mitral Valve Prolapse	Yes	No
Heart Murmur	Yes	No	Anemia	Yes	No
Scarlet Fever	Yes	No	Artificial Heart Valve	Yes	No
Heart Pace Maker	Yes	No	Heart Surgery	Yes	No
High Blood Pressure	Yes	No	Blood Disease	Yes	No
Tuberculosis	Yes	No	Diabetes	Yes	No
Epilepsy/ Seizure	Yes	No	Asthma	Yes	No
Rheumatic Fever	Yes	No	Artificial joint, prosthesis	Yes	No
Shortness of Breath	Yes	No	Sickle Cell Disease	Yes	No
Leukemia	Yes	No	Recent Blood Transfusion	Yes	No
Chemotherapy	Yes	No	Lung Disease	Yes	No
Emphysema	Yes	No	Cancer	Yes	No
Ulcers	Yes	No	Excessive Thirst	Yes	No
Liver Disease	Yes	No	Hepatitis A (infectious)	Yes	No
Hepatitis B or C	Yes	No	Pain in Jaw Joints	Yes	No
Cortisone Medicine	Yes	No	AIDS	Yes	No
HIV Positive	Yes	No	Drug Addiction/Alcoholism	Yes	No
Kidney Problems	Yes	No	Renal Dialysis	Yes	No
Thyroid Disease	Yes	No	Stroke	Yes	No
Cold Sores/Fever Blisters	Yes	No	Fainting or Dizziness	Yes	No
Tumors or Growths	Yes	No	Nervousness	Yes	No
Psychiatric Care	Yes	No	Alzheimer's Disease	Yes	No
Allergies (Medicines)	Yes	No	Allergies (Pollen/Dust)	Yes	No
Need Premedication?	Yes	No	Sleep Apnea	Yes	No

Have you ever had any serious illness not listed above?

_____

Do you wish to talk to the dentist privately about anything?

I Certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any member if his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Signature of Patient:
(Parent or Guardian if minor) **X**_____ **Date:** _____

Fees & Payment

We make every effort to keep down the cost of your dental treatment. You can help by paying upon completion of each visit. An estimate of the charge for any procedure you may require will be given to you upon request. If you have dental insurance we will be glad to fill out the proper forms and file them, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge**. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorneys' fees, and court costs.**

Signature of Patient:
(Parent or Guardian if minor) **X**_____ **Date:** _____

Authorization for Assignment of Benefits

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of Patient:
(Parent or Guardian if minor) **X**_____ **Date:** _____