Patient Information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

First Name: _____ MI: _____ Last Name: _____

SS# _____ Birth Date: _____ Sex: (M) (F)

Address: _____ City: _____ St: _____ Zip _____

Cell Phone: _____ Home Phone: _____ Email: _____

Social Security # _____ If patient is a Minor, Parents Social Security # _____

Spouse's or Parent's name: _____

Workplace _____ Work Phone: _____

If you are a student, name of School/College: _____ City: _____ State: _____

Person to Contact in case of emergency: _____ Phone: _____

How did you hear about Sterling Dental? If you were referred, by whom? _____

Insurance Information

Name of Insured: _____ Relationship to patient: _____

Birthday: _____ Social Security #: _____

Name of Employer: _____ Insurance Co: _____

Group #: _____ ID #_____

Dental History:

Former Dentist: _____

Reason for today's visit: _____

Date of last exam: _____ Date of last dental X-rays: _____

How often do you brush?: _____ How often do you floss?: _____

Please check any of the following conditions that apply to you:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or Popping Jaw
- ☐ Food collection between teeth
- ☐ Grinding Teeth
- ☐ Loose teeth or Broken Fillings
- ☐ Periodontal Treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

Primary Care Physician Information

Physician:_____ Date of last Visit: _____ Phone Number: _____

Initials _____

Medical History

Please list all medications you are currently taking: _____

_____

Have you ever taken any medications for osteoporosis (oral or IV) such as: Bisphosphontes, Fosamax, Boniva, Actonel, Atelvia, Reclast?
☐ Yes ☐ No If Yes, Which? _____

Allergies: ☐ Latex ☐ Codeine ☐ Aspirin ☐ Penicillin ☐ Novocain ☐ Metals ☐ Sulfa

☐ Other _____

(Women) Are you Pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking Birth Control Pills? ☐Yes ☐ No

Any History or current Tobacco use? If so, what kind, how much, and how long? _____

Unusual reaction to dental injections? _____

Do you have a history of the following?

☐ AIDS	☐ Chemo Therapy	☐ Hemophilia	☐Radiation Treatment	☐ Venereal Disease
☐ Anemia	☐ Circulatory Problems	☐ Hepatitis	☐ Respiratory Disease	
☐ Angina	☐ Cortisone Treatments	☐ High Blood Pressure	☐ Shortness of Breath	
☐ Arthritis, Rheumatism	☐ Cough, Persistent	☐ HIV Positive	☐ Skin Rash	
☐ Artificial Heart Valves	☐ Diabetes	☐ Hospitalizations	☐ Snoring	
☐ Artificial Joints	☐ Epilepsy/Seizures	☐ Jaw Pain	☐ Stroke	
☐ Asthma	☐ Fainting	☐ Kidney Disease	☐ Swelling of feet or ankles	
☐ Back Problems	☐ Glaucoma	☐ Liver Disease	☐ Thyroid Problems	
☐ Bed Wetting	☐ Headaches	☐ Lupus	☐ Tobacco Habit	
☐ Blood Disorder	☐ Heart Murmur	☐ Mitral Valve Prolapse	☐ Tonsillitis	
☐ Cancer	☐ Heart Problems	☐ Pacemaker	☐ Tuberculosis	
☐ Chemical Dependency	Describe _____	☐ Psychiatric Care	☐ Ulcer	

If you have any other Medical conditions or are scheduled for any procedures please describe:

_____

_____

Authorization

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 payers 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 for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Upon default in payment by patient or legal guardian, Family Gentle Dentist may charge patient/legal guardian attorney fees equal to 1/3 of the outstanding balance, court costs, delinquent charges, and collect as permitted by law. All payments after 90 days shall be assessed interest at 18% per annum.

Patient or Legal Guardian Signature: _____ Date: _____