## PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to help you.

### PERSONAL

**Patient** First Name _____ M.I. _____ Last Name _____

Date of Birth (MM/DD/YYYY) _____ SS# _____ Gender: ☐M ☐F Married: ☐Y ☐N

Cell Phone ( ____ )_____ Work Phone ( ____ )_____ Email _____

***If the patient is under 18 years old, please also complete the following guarantor information:***

***Guarantor*** *First Name* _____ *M.I.* _____ *Last Name* _____

*Date of Birth (MM/DD/YYYY)* _____ *SS#* _____ *Relationship to Patient* _____

*Cell Phone ( ____ )* _____ *Work Phone ( ____ )*_____ *Email* _____

**Preferred Contact Method** ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Text ☐ Email

**How did you hear about us?** _____

(If someone referred you here, please write down their name so that we can thank them.)

### ADDRESS AND HOME PHONE

Check this box if same address for the entire family: ☐ Home Phone ( ____ )_____

Address _____

City _____ State _____ Zip _____

### INSURANCE POLICY 1

Patient relationship to subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name _____ Subscriber ID # _____

Insurance Company _____ Phone ( ____ )_____

Employer _____ Group Name _____ Group # _____

** Please present insurance card to receptionist. **

### INSURANCE POLICY 2

Patient relationship to subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name _____ Subscriber ID # _____

Insurance Company _____ Phone ( ____ )_____

Employer _____ Group Name _____ Group # _____

### ASSIGNMENT AND RELEASE

I, the undersigned, understand that I am financially responsible for all charges. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Patient/Guarantor Signature **X**_____ Date **X**_____

PearlFamilyDentistry
Catch a Smile

## DENTAL HEALTH

Do you have ☐ Bleeding gum ☐ Sensitive to hot or cold ☐ Jaw problem ☐ Bad breath ☐ Teeth clenching/grinding

How often do you brush your teeth? _____ times a day

How often do you floss? _____ times a day

Have you ever had any orthodontic treatment? ☐ Yes ☐ No

Reason for today's visit: _____ Are you in pain? ☐ Yes ☐ No

## MEDICAL HISTORY

Name of Medical Doctor _____ City/State _____

Emergency Contact _____ Phone ( ____ )_____ Relationship _____

List all the medications that you are currently taking:

☐ None

_____

_____

_____

_____

List all the medications that you are allergic to:

☐ None ☐ Local Anesthetics

☐ Aspirin ☐ Metals

☐ Codeine/Other Narcotics ☐ Penicillin

☐ Erythromycin ☐ Sulfa Drugs

☐ Latex Rubber ☐ Other: _____

Check any medical conditions that you may have:

☐ None
☐ AIDS/HIV
☐ Anemia
☐ Artificial Heart Valve
☐ Arthritis
☐ Asthma/Hay Fever
☐ Blood Clotting Problems
☐ Blood Transfusion
☐ Bronchitis
☐ Cancer/Tumor or Growth
☐ Cardiac Pacemaker
☐ Chest Pain Upon Exertion
☐ Damaged Heart Valve
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Fainting Spells/Seizures
☐ Fever Blisters/Herpes
☐ Frequent Headaches
☐ Frequently Dry Mouth/Sjogren
☐ Glaucoma
☐ Heart Attack/Angina
☐ Heart Disease
☐ Hepatitis/Jaundice
☐ High Blood Pressure
☐ Hives/Skin Rash
☐ Joint Replacement, Date: _____
☐ Kidney/Bladder Trouble
☐ Low Blood Pressure
☐ Osteoporosis
☐ Psychiatric Problems
☐ Radiation Therapy, Chemotherapy
☐ Rheumatic Fever
☐ Sinus Trouble
☐ Stroke
☐ Surgery
☐ Thyroid Problems
☐ Tuberculosis
☐ Pregnant (If Female)
☐ Other: _____

By signing below, I certify that all of the above information is true to the best of my knowledge. I also understand that this information will be held in confidence and it is my responsibility to inform this office of any change in my medical status.

Patient/Guarantor Signature **X**_____ Date **X**_____

Patient/ Guarantor Name (Printed) _____