PATIENT INFORMATION

Welcome to Pearl Family Dentistry

PERSONAL

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

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

Cell Phone (____)_____ Email _____

Employer _____ Work Phone (____)_____

If the patient is under 18, please also complete the following information:

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

Date of Birth (MM/DD/YYYY) _____ 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 _____

Dental Insurance

Patient relationship to subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name _____ Subscriber ID # _____

Insurance Company _____ Phone (____)_____

Employer _____ Group Name _____ Group # _____

Secondary Insurance [ ] Yes [ ] No

No Show Policy

Please understand that when we schedule your appointment, we are reserving time for your particular needs. We kindly ask that if you must change an appointment, please give us at least 24 hours' notice. This courtesy makes it possible to give your reserved time to another patient who would like it.

A "No Show/ Late Cancellation" is defined as missing an appointment without cancelling at least 24 hours before scheduled time. Patients who do not show up for appointment or cancel without 24-hour notice will be charged **$35** per appointment scheduled. The fee must be paid before you or your family member is seen in our office again. Three failed appointments may result in dismissal from the practice

If you are running more than ten minutes late, we may ask you to reschedule your appointment.

Signature _____ **Date** _____

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**_____

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) _____