WELCOME TO SURRATT FAMILY DENTAL

PATIENT INFORMATION

Name: _____ Who may we thank for referring you?: _____

Gender: M ▢ F ▢ Address: _____ City/State/Zip: _____

Home phone: (____) _____ Work phone: (____) _____ Cell phone: (____) _____

Email: _____ Best time to reach you: _____

Birthdate: _____ Age: _____ SSN#: _____

Patient or Parent/Guardian's Employer: _____ Occupation: _____

If student, name of school/college:_____ City: _____ State: _____Full-Time ▢ Part-Time ▢

Minor ▢ Single ▢ Married ▢ Divorced ▢ Widowed ▢ Separated ▢

Spouse or Parent/Guardian's Name: _____ Employer: _____

Work phone: (____) _____ Cell phone: (____)_____ Email: _____

RESPONSIBLE PARTY

(If someone other than the patient is responsible for the account)

Name of Person Responsible for Patient:_____ Phone: (____) _____

Relationship to Patient: _____ Is this person currently a patient in our office? Y ▢ N ▢

Address: _____ City/State/Zip: _____ Birthdate: _____

Email: _____ Driver's License #: _____ SSN#: _____

Financial Institution: _____ Employer: _____ Work phone: (____) _____

We offer various options of payment. Please check the option you prefer. Payment in full at each appointment:

Cash ☐ Check ☐ Credit Card ☐ MasterCard ☐ VISA ☐ I wish to discuss the office's payment policy ☐

INSURANCE INFORMATION

Name of insured: _____ Birthdate: _____ SSN#: _____

Relationship to Patient _____ Name of Employer: _____

Address of Employer: _____ City/State/Zip: _____ Work Phone: (____) _____

Insurance company: _____ Grp #: _____ ID#: _____

Insurance Company Address: _____ Ins Co. Phone: (____) _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit: _____

Union of Local #: _____ Is there secondary insurance coverage? Y ▢ N ▢

Name of insured: _____ DOB: _____ SSN#: _____

Relationship to Patient: Self ▢ Spouse ▢ Child ▢ Other ▢ _____

Insurance company: _____ Grp #: _____ ID#: _____

Insurance Company Address: _____ Ins Co. Phone: (____) _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit: _____

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MEDICAL HISTORY

Physician _____ Office Phone: (____) _____ Date of Last Exam: _____

Are you under a medical treatment care now? Y ☐ N ☐
If yes, please explain: _____

Have you ever been hospitalized or had a surgical operation or serious illness within the last five years? Y ☐ N ☐
If yes, please explain: _____

Are you taking any medication(s), including non-prescription medicine? Y ☐ N ☐
If yes, what medication(s) are you taking?: _____

Do you take, or have you taken, Phen-Fen or Redux? Y ☐ N ☐

Do you take, or have you taken, Fosmax, Bondhus, Actonel or any cancer medications constrining bisphosphonates? Y ☐ N ☐
If yes, what medication(s) are you taking?: _____

Do you take, or have you taken, Viagra, Revatio, Cialis or Levitra in the last 24-hours? Y ☐ N ☐
If yes, please explain: _____

Do you use tobacco? Y ☐ N ☐
Do you use controlled substances? Y ☐ N ☐
Are you wearing contact lenses? Y ☐ N ☐

Are you allergic or have had any reactions to any of the following?

Aspirin ☐ Penicillin ☐ Metal(s) ☐ Latex Rubber ☐ Local Anesthetics ☐ Sulfa Drugs ☐ Barbiturates ☐

Sedatives ☐ Iodine ☐ Other ☐ If other, please explain: _____

Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? If yes, please explain: _____

Do you have, or have had, any of the following?

Y ☐ N ☐ AIDS/HIV
Y ☐ N ☐ Alzheimer's Disease
Y ☐ N ☐ Anemia
Y ☐ N ☐ Angina
Y ☐ N ☐ Arthritis/Gout
Y ☐ N ☐ Asthma
Y ☐ N ☐ Cancer
Y ☐ N ☐ Chest Pains
Y ☐ N ☐ Diabetes
Y ☐ N ☐ Easily Winded
Y ☐ N ☐ Low Blood Pressure
Y ☐ N ☐ Mitral Valve Prolapse
Y ☐ N ☐ Radiation Therapy
Y ☐ N ☐ Recent Weight Loss
Y ☐ N ☐ Emphysema
Y ☐ N ☐ Epilepsy or Seizures
Y ☐ N ☐ Fainting Spells/ Dizziness
Y ☐ N ☐ Frequently Tired
Y ☐ N ☐ Glaucoma
Y ☐ N ☐ Hay Fever/Allergies
Y ☐ N ☐ Heart Attack/Failure
Y ☐ N ☐ Heart Murmur
Y ☐ N ☐ Cardiac Pacemaker
Y ☐ N ☐ Respiratory Problems
Y ☐ N ☐ Rheumatic Fever
Y ☐ N ☐ STDs
Y ☐ N ☐ Stomach/Intestinal Disease
Y ☐ N ☐ Heart Trouble/Disease
Y ☐ N ☐ Hepatitis A
Y ☐ N ☐ Hepatitis B or C
Y ☐ N ☐ High Blood Pressure
Y ☐ N ☐ Jaundice
Y ☐ N ☐ Joint Replacement or Implant
Y ☐ N ☐ Kidney Diseases
Y ☐ N ☐ Leukemia
Y ☐ N ☐ Liver Disease
Y ☐ N ☐ Stroke
Y ☐ N ☐ Thyroid Problems
Y ☐ N ☐ Tuberculosis
Y ☐ N ☐ Ulcers

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Have you ever had any serious illness not listed above? Y ☐ N ☐
If yes, please explain:_____

Other comments: _____

Women ONLY:

Are you pregnant or think you may be pregnant? Y ☐ N ☐
Are you taking oral contraceptives? Y ☐ N ☐
Are you nursing? Y ☐ N ☐

PATIENT DENTAL HISTORY

Name of Previous Dentist _____ Location: _____ Date of Last Exam: _____

Do your gums bleed while brushing or flossing? Y ☐ N ☐
Are your teeth sensitive to hot or cold liquids/foods? Y ☐ N ☐
Are your teeth sensitive to sweet or sour liquids/foods? Y ☐ N ☐
Do you feel pain to any of your teeth? Y ☐ N ☐
Do you have any sores or bumps in or near your mouth? Y ☐ N ☐
Have you had any head, neck, or jaw injuries? Y ☐ N ☐
Do you have frequent headaches? Y ☐ N ☐
Do you clench or grind your teeth? Y ☐ N ☐
Do you bite your lips or cheeks frequently? Y ☐ N ☐

Have you ever had any difficult extractions in the past? Y ☐ N ☐
Have you ever had any prolonged bleeding following extractions? Y ☐ N ☐
Have you had any orthodontic treatment? Y ☐ N ☐
Do you wear dentures or partials? Y ☐ N ☐
If yes, what was the date of placement?: _____
Have you ever received oral hygiene instructions regarding Y ☐ N ☐
the care of your teeth and gums? Y ☐ N ☐
Do you like your smile? Y ☐ N ☐

Have you ever experienced any of the following problems in your jaw? Y ☐ N ☐
Clicking Y ☐ N ☐
Pain (join, ear, side of face) Y ☐ N ☐
Difficulty in opening or closing Y ☐ N ☐
Difficulty in chewing Y ☐ N ☐

Signature needed

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 theird party paers others payable ot me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be resonpsible for payment of all services rendered on my behalf or my dependents.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____