THE BITING EDGE, P.C. FAMILY DENTISTRY

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More Than Just a Smile | *Aesthetic, Contemporary Restorative & Cosmetic Rehabilitation*

NEW PATIENT INFORMATON

About You

Name

(First) (MI) (Last)

☐ Mr. ☐ Mrs ☐ Ms. ☐ Dr. I prefer to be called:

Birthdate: SS#:

Home Address:

City: State: Zip:

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Phone: Mobile:

Work Phone: Email:

Employer: Occupation:

Where & When are best times to reach you?

Who may we thank for referring you?

Other family members seen by us:

Spouse Information

His/Her Name:

(First) (MI) (Last)

Birthdate: SS#:

Employer: Occupation:

Home Phone: Mobile:

Work Phone: Email:

Emergency Contact

In the event of an emergency, who would you like us to contact?

Name:

Relationship:

Home Phone: Mobile:

Work Phone: Extention:

Dental Insurance

Primary Dental Insurance

Name of Insurance Co.:

Address:

Phone #:

Group #:

Insured's Name:

Relation:

Insured's Birthday: Insured's SS#:

Insured's Employer:

Secondary Dental Insurance

Name of Insurance Co.:

Address:

Phone #:

Group #:

Insured's Name:

Relation:

Insured's Birthday: Insured's SS#:

Insured's Employer:

Financial Responsibility

This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection in the event of default. I further understand that if a payment becomes 45 days past due, delinquency at the lesser of the monthly rate of 1.5%, or the maximum allowable rate, will be due on delinquent amounts from the date the payment was due. There will be a $20.00 charge for returned checks.

Signature: Date:

Medical History

Are you currently under the care of a physician? If YES, Name:

Do you have a personal physician?

Physician's name: Phone #:

Describe your current physical health: ☐ Excellent ☐ Fair ☐ Poor

Do you Smoke or use Smokeless Tobacco? ☐ Yes ☐ No Specify:

FOR WOMEN: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No If Yes, #of weeks ______________ Are you nursing? ☐ Yes ☐ No

Are you currently taking any ☐ prescriptions, ☐ over the counter drugs, ☐ herbal supplements or ☐ appetite suppressants?

List All Current Medications

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Diabetes	Y	N	Liver Disease
Y	N	Alcohol or Drug Abuse	Y	N	Emphysema	Y	N	Low Blood Pressure
Y	N	Allergies	Y	N	Epilepsy	Y	N	Mitral Valve Prolapse
Y	N	Alzheimer's Disease	Y	N	Fainting Spells	Y	N	Nervous Problems
Y	N	Anemia	Y	N	Fever Blisters/Herpes	Y	N	Pace Maker
Y	N	Arthritis	Y	N	Frequent Headaches	Y	N	Psychiatric Problems
Y	N	Artificial Joints/Bones	Y	N	Glaucoma	Y	N	Radiation Treatment
Y	N	Artificial Heart Valves	Y	N	Hay Fever	Y	N	Rheumatic/Scarlet Fever
Y	N	Asthma	Y	N	Heart Problems	Y	N	Seizures
Y	N	Back Problems	Y	N	Heart Attack	Y	N	Shingles
Y	N	Blood Transfusion	Y	N	Heart Surgery	Y	N	Sickle Cell Disease
Y	N	Cancer/Chemotherapy Treatment	Y	N	Hemophilia	Y	N	Sinus Problems
Y	N	Circulatory Problems	Y	N	Hepatitis (Circle) A B C	Y	N	Stroke
Y	N	Chronic Diarrhea	Y	N	High Blood Pressure	Y	N	Thyroid Problems
Y	N	Colitis	Y	N	HIV+ or AIDS	Y	N	Tuberculosis (TB)
Y	N	Cosmetic Surgery	Y	N	Kidney Problems	Y	N	Ulcers

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Dental Anesthetics
Y	N	Latex	Y	N	Tetracycline
Y	N	Codeine	Y	N	Erythromycin
Y	N	Penicillin	Y	N	Other - List:

Dental History

Why have you come to the dentist today?

Are you currently in pain or discomfort with you teeth and/or gums? ☐ Yes ☐ No

How would you describe the condition of your teeth and gums? ☐ Excellent ☐ Fair ☐ Poor

Previous Dentist: Last Visit Date:

Have you had orthodontics? ☐ Yes ☐ No If YES, at what age?

Do you have headaches? ☐ Yes ☐ No If YES, how often?

Are you interested in fewer dental appointment dates? ☐ Yes ☐ No

Questionnaire

Y N Do you feel you are meticulous with your oral hygiene?

Y N Do you understand the correlation between dental plaque control and the prevention of gum disease?

Y N Do your gums ever bleed?

Y N Have you ever been told you have gum disease?

Y N Do you grind or clench your teeth?

Y N Have you ever had pain/discomfort in your jaw joint?

Y N Would you like to keep your natural teeth for as long as you live?

Y N Do you get frustrated that you need work done every time you go to the dentist?

Y N Would you like to have whiter teeth?

Y N Would you like your teeth to be straighter?

Y N Are you unhappy with any silver or discolored fillings?

Y N Do you have crowns or bridges which are unattractive or unnatural looking?

Y N Do you sometimes feel uncomfortable with the appearance of your smile?

Y N Are your teeth crooked or crowded?

Y N Do you have one or more missing teeth?

Y N Do you have unattractive spaces between your teeth?

Y N Do you think a more attractive smile would improve your personal and/or professional relationships?

Y N Do you often feel as if your breath is not as fresh as it could be?

Y N Have you ever been told that you have "bad breath"?

What level of dental care do you think your dental insurance company will cover? ☐ Excellent ☐ Fair ☐ Poor

What level of dental care would you like to have for yourself? ☐ Excellent ☐ Fair ☐ Poor

The information that I have given is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

I authorize any photographs or slides to be taken of me during treatment at The Biting Edge P.C., Family Dentistry for educational purposes, laboratory fabrication, or internal office use. I fully understand that other dentists, team members, and other patients may view these photos for educational and/or treatment purposes.

Signature: Date:

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ____,

have received a copy of this office's Notice of Privacy Practices.

____
{Please Print Name}

____
{Signature}

____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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