Michaela Walker's Family Dentistry
Patient Information

PATIENT INFORMATION

Patient name: _____ Birth Date: _____ Todays Date: _____
□ Male □ Female □ Decline to specify □ Single □ Married □ Divorced □ Widowed □ Separated
Social Security #: _____ _____ Driver's License #: _____
Address: _____ City:_____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email address: _____
Emergency Contact Name: _____ Phone number _____
Who may we thank for referring you? □ Family/Friend and Their Name: _____
□ Insurance Company □ Internet □ Other: _____

SPOUCE/LIFE PARTNER INFORMATION

Name: _____ Birth Date: _____
□ Male □ Female Social Security #: _____ Driver's License #: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email address: _____
Employer: _____

PATIENT EMPLOYER INFORMATION

Employer: _____ Employer Phone #: _____
Employer Address: _____ City:_____ State: _____Zip: _____

HEALTH INFORMATION

Have you ever had any of the following? Please check those that apply.

□ AIDS/HIV Positive
□ Anemia
□ Arthritis
□ Artificial Heart Valves
□ Artificial Joints
□ Asthma
□ Blood Disorder; Please specify _____
□ Cancer
□ Chemical Dependency
□ Chemotherapy
□ Circulatory Problems
□ Cough, Persistent or Bloody
□ Diabetes: Type I II Most recent A1c:_____
□ Emphysema
□ Epilepsy
□ Excessive Bleeding
□ Fainting/Dizziness
□ Glaucoma
□ Hay Fever
□ Head Injuries
□ Heart Attack When?: _____
□ Heart Disease
□ Heart Murmur
□ Hemophilia
□ Hepatitis; Please specify A/B/C
□ High Blood Pressure
□ Jaundice
□ Kidney Disease
□ Liver Disease
□ Mental Disorders/Depression/Anxiety
□ Mitral Valve Prolapse
□ Nervous Disorders
□ Osteoporosis
□ Pacemaker
□ Radiation treatment
□ Respiratory Disease
□ Rheumatic Fever
□ Rheumatism
□ Scarlet Fever
□ Stomach Problems/Ulcers
□ Sinus problems
□ Stroke When?: _____
□ Tuberculosis
□ Tumors
□ Thyroid
□ STD

Please list any medications you are currently taking: _____
_____
_____
_____
_____

Are you allergic to anything? _____

Are you now under the care of a physician? □ Yes □ No

If yes, please explain: _____

Name of Physician: _____

Physician Address: _____ City:_____ State: _____ Zip: _____

Physician Phone Number: _____

Is there any other medical or dental information you feel I should know about? □ Yes □ No

If yes, please explain: _____

[For office use] BP: _____

DENTAL INFORMATION

Please check any of the following that apply to you:

□ Sensitivity (cold, hot, sweet, chewing)
Where? UR, UL, LR, LL How long? _____
□ Headaches, neck, or jaw pain
□ Clicking or popping jaw
□ Dry Mouth
□ Mouth ulcers or cold sores
□ Teeth or fillings breaking
□ Grinding or clenching teeth
□ Bleeding, swollen, irritated gums
□ Loose, chipped, or shifting teeth
□ Bad breath

Do you have to premedicate with antibiotics before dental appointments? □ Yes □ No

Have you ever had any complications following dental treatment? □ Yes □ No

If yes, please explain: _____

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

□ Dentures □ Braces (traditional or Invisalign) □ Gum Treatments

Please share the following dates:

Your last cleaning: _____

Your last oral cancer screening: _____

Your last complete x-rays: _____

Name of Previous Dentist: _____

Previous Dentist Address: _____ City: _____ State: _____

Why did you leave your previous dentist? _____

Have you ever wanted to whiten you teeth or to learn more about teeth whitening? □ Yes □ No

Is keeping your teeth important to you? □ Yes □ No

Do you smoke or use chewing tobacco? □ Yes □ No How much? _____ For how long? _____

If you could change your smile, would you:

□ Straighten your teeth
□ Replace metal fillings with tooth colored fillings
□ Repair chipped teeth
□ Replace missing teeth
□ Replace old crowns that don't match
□ Have a smile makeover

On a scale of 1-10; 10 being the highest:

How important is your dental health?
1 2 3 4 5 6 7 8 9 10

What would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your future smile and dental health? _____

What is the most important thing to you about your dental visit today? _____

What is would be your biggest barrier to getting dental treatment completed?

□ Dental Anxiety
□ Money
□ Other: _____
□ Time
□ Trust

DENTAL INSURANCE INFORMATION (PRIMARY)

Person Responsible for Account: _____
Relation to Patient: _____ Birth Date: _____ Social Security #: _____
Address (if different from patients): _____ City: _____
State: _____ Zip: _____ Phone #: _____
Business Address: _____ City: _____
State: _____ Zip: _____ Business Phone #: _____
Insurance Company: _____
Contract #: _____ Group #: _____ Subscriber #: _____
Names of other dependents covered under this plan: _____

DENTAL INSURANCE INFORMATION (SECONDARY)

Is patient covered by additional insurance? □ Yes □ No
Subscriber name: _____ Relation to Patient: _____ Birthdate: _____
Address (if different from patients): _____ City: _____
State: _____ Zip: _____
Subscriber Employed by: _____ Business Phone #: _____
Insurance Company: _____
Contract #: _____ Group #: _____ Subscriber #: _____
Names of other dependents covered under this plan: _____

AUTHORIZATION

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.