L'ENFANT PLAZA DENTAL ARTS

PATIENT INFORMATION

Name ________________________ Birthdate ________________________ Home Phone ________________________

Address _____________________________________ City _____________State __________Zip __________________

E-mail Address ____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or Parent's Employer ___________________________________ Work Phone ________________________

Business Address _____________________________City________________State ____________ Zip ______________

Spouse or Parent's Name __________________ Employer _____________ Work Phone _______________________

If Patient is a student, Name of School/College ______________________City __________ State ________________

Whom may we thank for referring you? ________________________

Person to contact in case of emergency _____________________________ Phone ___________________________

RESPONSIBLE PARTY

Name of Person responsible for this account ________________________ Relation to patient _________________

Address ____ Home Phone ____________________________________

Driver's License #____________________________________ Birthdate _____________________________________

Employer ____________________________________ Work Phone ____

Currently a patient in our office? ☐ Yes ☐ No

INSURANCE INFORMATION

Name of Insured _____________________________________ Relation to patient _____________________________

Birthdate ___________________ SSN# ______________________________ Date Employed _____________________

Employer ____ Work Phone ___________________________________

Employer Address _____________________________ City ______________State __________Zip _________________

Insurance Company City _________________ Group # ___________________ Union or local # __________________

Address _____________________________ City ________________State ______________Zip ____________________

ADDITIONAL INSURANCE

Name of Insured _____________________________________ Relation to patient _____________________________

Birthdate ___________________ SSN# ______________________________ Date Employed _____________________

Employer ____ Work Phone ___________________________________

Employer Address _____________________________ City ______________State __________Zip _________________

Insurance Company City _________________ Group # ___________________ Union or local # __________________

Address _____________________________ City ________________State ______________Zip ____________________

DENTAL HISTORY

Reason for today's visit ____

Former Dentist ____

Address ____

Date of last dental visit _________________________ Date of last dental X-rays______________________________

Check (✓) if you have had any of the following:

☐ Bad breath ☐ Grinding teeth ☐ Sensitivity to heat

☐ Bleeding gums ☐ Loose teeth or broken fillings ☐ Sensitivity to sweets

☐ Clicking or popping jaw ☐ Periodontal treatment ☐ Sensitivity when biting

☐ Food collection between the teeth ☐ Sensitivity to cold

☐ Sores or growths in your mouth

How often do you brush? ________________________ How often do you floss? ______________________________

MEDICAL HISTORY

Physician's Name __________________________________ Date of last visit _________________________________

Have you had any serious illnesses or operations? ☐ Yes ☐ No if yes, describe ________________________

Have you ever had blood transfusion? ☐ Yes ☐ No if yes, give approximate dates __________________________

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have had any of the following:

☐ AIDS	☐ Cortisone Treatments	☐ Hepatitis	☐ Rheumatic Fever
☐ Anemia	☐ Cough Persistent	☐ High Blood Pressure	☐ Scarlet fever
☐ Arthritis	☐ Cough up Blood	☐ HIV Positive	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Diabetes	☐ Jaw Pain	☐ Skin Rash
☐ Artificial Joints	☐ Epilepsy	☐ Kidney Disease	☐ Stroke
☐ Asthma	☐ Fainting	☐ Liver Disease	☐ Swelling of feet or Ankles
☐ Back Problems	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Thyroid Problems
☐ Blood Disease	☐ Headaches	☐ Nervous Problems	☐ Tobacco Habits
☐ Cancer	☐ Heart Murmur	☐ Pacemaker	☐ Tonsillitis
☐ Chemical Dependency	☐ Heart Problems	☐ Psychiatric Care	☐ Tuberculosis
☐ Chemotherapy	Describe ____________	☐ Radiation	☐ Ulcer
☐ Circulatory Problems	☐ Hemophilia	☐ Respiratory Disease	☐ Venereal Disease

MEDICATIONS ALLERGIES

List medications you are currently taking:

______________________________________ ______________________________________

______________________________________ ______________________________________

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize and request insurance company to pay directly to the dentist or dental insurance benefits otherwise payable to me. I authorize the doctor 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. I authorize the use of this signature on all insurance submissions.

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Signature of patient or parent (if minor) Date