



# Distinctive Dental Arts

# WELCOME

## Patient Information (*Confidential*)

Male  Female

Name: \_\_\_\_\_

Last

First

MI

Title

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated  Domestic Partner

### Emergency

Contact: Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Cell # \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

## Insurance Verification

As a courtesy to our patients, we will file your dental claim. Although we do participate with insurances, your insurance is a contract between you or your employer and your insurance company. Ultimately YOU are responsible for your account, regardless of what your insurance does or does not pay. Please understand that dental insurance is intended to cover some, but not all, of the cost of your dental care, and may include a deductible which must be paid by the patient at the time of service.

**We cannot stress enough that insurance payment is not, and has never been, a guideline for quality care.**

### ■ Dental Insurance Only ■

Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Subscriber SSN/ID: \_\_\_\_\_ Subscriber Employer: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Insurance Company Phone: \_\_\_\_\_ Group Number: \_\_\_\_\_

### ■ Assignment and Release ■

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Distinctive Dental Arts all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of his signature on all insurance submissions.

Responsible Party Signature: \_\_\_\_\_

Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

# Distinctive Dental Arts

## Medical History (*Confidential*)

Physician's Name: \_\_\_\_\_

Physician's Phone: \_\_\_\_\_

Date of last visit: \_\_\_\_\_

Your current physical health is:  Good  Fair  Poor

Are you currently under the care of a physician?  Yes  No

Please explain: \_\_\_\_\_

Do you use tobacco in any form?  Yes  No

Are you taking any medications?  Yes  No

Please list each one: \_\_\_\_\_

Have you ever had any surgical procedures?  Yes  No

Please list each one: \_\_\_\_\_

Yes	No	Conditions
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse
<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Angina Pectoris
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion
<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy
<input type="checkbox"/>	<input type="checkbox"/>	Colitis
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defect
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing
<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis / Osteopenia

Yes	No	Conditions
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	HIV+ AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur
<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery
<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems
<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse
<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems
<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease

Yes	No	Conditions
<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers

Yes	No	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Aspirin
<input type="checkbox"/>	<input type="checkbox"/>	Codeine
<input type="checkbox"/>	<input type="checkbox"/>	Dental Anesthetics
<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin
<input type="checkbox"/>	<input type="checkbox"/>	Jewelry
<input type="checkbox"/>	<input type="checkbox"/>	Latex
<input type="checkbox"/>	<input type="checkbox"/>	Metals
<input type="checkbox"/>	<input type="checkbox"/>	Penicillin
<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline
<input type="checkbox"/>	<input type="checkbox"/>	Sulfur
<input type="checkbox"/>	<input type="checkbox"/>	Iodine

• Have you had any metal rods, pins or joint replacements (hip, knee, other)?  Yes  No

• Do you need antibiotics before your dental appointment?  Yes  No

• Have you ever or currently take any bone-strengthening medications (Fosamax, Actonel, Prolia, etc.)?  Yes  No

Yes	No	If Female, Please Answer
<input type="checkbox"/>	<input type="checkbox"/>	Are you taking Birth Control Pills?
<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant? If so, # of Weeks _____
<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing?

I understand that the information that I have given today is correct to the best of my knowledge. I also 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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Distinctive Dental Arts

## Dental History (*Confidential*)

Name: \_\_\_\_\_

How may we help you today? \_\_\_\_\_

Your current dental health is:  Good  Fair  Poor

Do you require antibiotics before dental treatment?  Yes  No

Are you currently in pain?  Yes  No

Have you ever had gum treatment?  Yes  No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ)  Yes  No

**Circle** all that you are concerned about / currently have:

Cavities	Fear of dentistry	Headaches	Gum disease
Clicking jaw	Want whiter teeth	Broken teeth	Loose teeth
Want to save teeth	Broken fillings	Spacing	Poor dentistry
Missing teeth	Grinding/clenching	Want gentle dentist	Dark/Ugly teeth
Snoring / Apnea	Recession	Crooked teeth	Bleeding gums
Cosmetic dentistry	Bad breath	Jaw or face pain	Nothing

Is there anything you would like to change about your smile?  Yes  No

Are you happy with the color of your teeth?  Yes  No

Do your gums bleed?  Yes  No

Are your teeth sensitive to hot, cold or anything else?  Yes  No

Have you ever had a serious/difficult problem with any previous dental work?  Yes  No

Have you ever had any unfavorable dental experiences?  Yes  No

Have you ever had difficulty with numbing your teeth?  Yes  No

When was your last dental cleaning? \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_

Why did you leave your previous dentist? \_\_\_\_\_

How can we accommodate you better during your dental visit? \_\_\_\_\_

Here at Distinctive Dental Arts we offer a wide variety of services to enhance and keep your smile beautiful. Please **circle** any services below you would like our staff to discuss with you during your visit.

Tooth Whitening

Veneers

Invisalign

Sealants

Smile Makeover

Bonding

Partials/Dentures

Crown and Bridge

Implant Crowns

Night/Sport Guards