

CARROLLTON



DENTAL STUDIO

Reason for Visit / Main Concern? Check-Up [] Cleaning [] Toothache [] Other _____

Patient Name: _____ Birth Date: _____
Cell Phone: _____ Gender: Male [] Female [] Other []
Address: _____
E-mail: _____ Primary Language _____

OCCUPATION: _____ **EMERGENCY CONTACT:** _____
Employer: _____ Relationship: _____
Social Security #: _____ Phone: _____

INSURANCE / DENTAL PLAN

Insurance Carrier: _____ Insurance Phone #: _____
Subscriber Name: _____ Date of Birth: _____
Employer: _____ Social Security #: _____
Member ID: _____ Address: _____

PHARMACY

Pharmacy Name: _____ Phone: _____
Address _____

Please list any surgeries or hospitalizations you have had and their dates:

Please list any allergies (penicillin,, local anesthetics, or any other drugs or medicine, etc.):

Are you currently taking any medications or supplements? If yes, please list:

DENTAL HISTORY

When did you last visit a dentist? _____
When were dental x-rays taken? _____
When was your last dental cleaning? _____
Have you had gum or periodontal? _____
Do your gums bleed easily? _____
Do you feel you have bad breath? _____
Do you have difficulty flossing? _____
Are your teeth sensitive to hot or cold? _____
Do you grind your teeth or have symptoms near
your ears such as clicking, popping, pain or
locking open? _____
Do you brush your teeth regularly? _____
Do you smoke? If yes, how often and for how
long? _____

MEDICAL HISTORY

Please check any conditions you have or have
had in the past:

- Heart Disease
- High Blood Pressure
- Diabetes
- Asthma
- Arthritis
- Epilepsy
- Thyroid Problems
- Hepatitis
- Blood Transfusion
- Chemotherapy
- Kidney Trouble
- Liver Disease
- Sinus Trouble
- Stroke
- Cancer

Are there any other health problems? Please
specify: _____

1. I certify that the information provided is accurate. I understand that I am financially responsible for the charges not covered by or paid by my insurance for whatever reason.
2. By signing below, I authorize that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.
3. I authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.
4. I understand that this dental practice is owned and operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist or corporate entity is responsible for my dental treatment.
5. By signing below, I authorize that you may send me email and text message appointment reminders, marketing material, and account updates, including electronic billing statements.

Signature: _____ Date: _____