



# Welcome TO OUR PRACTICE

*Thank you for trusting us with your dental care.  
We promise to do our best to provide you with  
the finest care available. If you have any  
questions please do not hesitate to call us.*

Patient # \_\_\_\_\_  
SS # \_\_\_\_\_  
Date \_\_\_\_\_

## PATIENT INFORMATION

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Sex  M  F  Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_\_\_ years  
E-mail \_\_\_\_\_ Cell Phone #1 (\_\_\_\_) \_\_\_\_\_ Cell Phone #2 (\_\_\_\_) \_\_\_\_\_  
Employer/School \_\_\_\_\_ Employer/School Phone (\_\_\_\_) \_\_\_\_\_  
Employer/School Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
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 \_\_\_\_\_ Bank \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
Currently a patient in our office?  Yes  No E-mail \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

## EXAM CONSENT

I, the undersigned patient, hereby authorize the providers at Mitchell Dental Clinic to perform the procedure(s) necessary for x-rays, examinations and / or a professional teeth cleaning.

\_\_\_\_\_  
Signature of patient, parent, guardian or personal representative

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Please print name

\_\_\_\_\_  
Relation

## PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

\_\_\_\_\_  
Signature of patient, parent, guardian or personal representative

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Please print name

\_\_\_\_\_  
Relation

## DENTAL HISTORY

Reason for today's visit \_\_\_\_\_ Date of last dental visit \_\_\_\_\_

Former Dentist \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_

Address \_\_\_\_\_

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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad breath                        | <input type="checkbox"/> Grinding teeth                 | <input type="checkbox"/> Sensitivity to heat            |
| <input type="checkbox"/> Bleeding gums                     | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets          |
| <input type="checkbox"/> Clicking or popping jaw           | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity when biting        |
| <input type="checkbox"/> Food collection between the teeth | <input type="checkbox"/> Sensitivity to cold            | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).  Yes  No

Have you had any serious illnesses or operations?  Yes  No If yes, describe \_\_\_\_\_

Have you ever had a 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:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Cough, Persistent    | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up Blood       | <input type="checkbox"/> HIV / AIDS            | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Osteoporosis          | <input type="checkbox"/> Tobacco Habit              |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Ulcer                      |
|  |   |  | <input type="checkbox"/> Venereal Disease           |

Medications:

List medications you are currently taking and the correlating diagnosis: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group 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.

Signature of patient or parent if minor \_\_\_\_\_

\_\_\_\_\_ Date

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