Bagnell Dental Clinic

Welcome! Thank you for selecting our dental health care team. We will strive to offer you the best quality care in a compassionate environment.

Patient Information (Confidential)

Last Name____ First Name____

Middle Name____ Prefix______ Preferred Name _______________________________

Date of Birth ____ Social Security No. ____

__Minor __Single __Married __Divorced __Widowed Gender: __Male __Female

Address ____ City _________________ State _____________ Zip _____________

Home Phone ____ Work Phone ____

Cell Phone ____ E-Mail ____

Whom may we thank for referring you ____

Responsible Party

____Same as patient

Name of Person Responsible for this account ____ Gender: ___Male ___Female

Date of Birth ____ Social Security No. ____

Relationship to Patient ___________________________________ Is this person a patient in our office? ___________________________

Address ____ City _________________________ State ___________ Zip________

Home Phone ____ Work Phone ____

Cell Phone ____ E-Mail ____

Insurance Subscriber Information

Name of subscriber ____ Gender ___Male ___Female

Insurance company ____ Group # ____________________________________

Policy # ____ Subscriber's Social Security No. ___________________________

Subscriber's Date of Birth _________________________ Employer Name _____________________________ Phone _____________

Patient's Relationship to subscriber: __Self __Spouse __Child/Stepchild

Secondary Insurance: If you have coverage from multiple insurance plans please advise us and present cards for photocopies.

Name of subscriber ____ Gender ___Male ___Female

Insurance company ____ Group # ___________________________________

Policy # ____ Subscriber's Social Security No. ___________________________

Subscriber's Date of Birth _________________________ Employer Name _____________________________ Phone _____________

Patient's Relationship to subscriber: __Self __Spouse __Child/Stepchild

The information on this page is correct to the best of my knowledge. I authorize the dentist to release any information including diagnosis and the records of treatment and examination rendered to me or my child during the period of such dental care to third party payers and or health practitioners. I authorize and request my insurance company pay directly to this dental office. I understand that my dental insurance may pay less than the actual cost of care and agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that if I am delinquent on my account I am responsible for any finance charges that may be assessed and should I default on payment of my account and collection agency services are required all cost of collection including attorney fees will be added to the balance of my account.

Signature of Patient (or guardian) ____ Date __________________________

Bagnell Dental Clinic

Medical and Dental History

Patient Name ___________________________DOB__________ Height _______ Weight _________

Medical History

Physician _______________________________________ Phone __________________ Last Visit ________________

__Yes __No Are you under a physician's care now? If yes, Why? ____

Physicians Name ____ Phone _____________________

__ Yes __ No Have you ever been hospitalized or had a major operation? What? ________________________________

__ Yes __ No Are you taking any medications? Please list ____

____

____

__Yes __ No Are you allergic to any medications or substances?

__ Acrylic __Aspirin __Codeine __ Latex __ Local Anesthetic __ Metal __ Penicillin __ other ____________________

____

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

__Yes __ No Arthritis	__ Yes __ No Epilepsy/Seizures	__ Yes __ No Kidney Disease
__Yes __ No Artificial Heart Valve	__Yes __ No Glaucoma	__Yes __ No Mitral Valve Prolapse
__Yes __ No Artificial Joint	__Yes __ No Heart Murmur	__Yes __ No Pacemaker
__Yes __ No Asthma	__Yes __ No Heart Surgery	__Yes __ No Radiation
__Yes __ No Bone Density Meds. Use	__Yes __ No Heart Trouble	__Yes __ No Venereal Disease
__Yes __ No Cancer	__Yes __ No Hepatitis _A _B _C	__Yes __ No Stroke
__Yes __ No Diabetes	__Yes __ No High Blood Pressure	__Yes __ No Thyroid Problems
__Yes __ No Endocarditis	__Yes __ No HIV/AIDS	__Yes __ No Tuberculosis

__Yes __ No Have you ever had any other serious illness not listed? ______________________________________

____

Women are you: __Pregnant If Pregnant, due date: ____________________ ___Nursing ___Taking Birth Control

Emergency contact: ____

Dental History

Previous Dentist ____Date of Last Visit ________________

Primary Reason for today's appointment ____

__Yes __ No Have you had problems with previous dental treatment?

__Yes __ No Are you apprehensive about dental care?

__Yes __ No Do your gums bleed when brushing or flossing?

__Yes __ No Do you use any tobacco products?

__Yes __ No Have you noticed sores in your mouth?

__Yes __ No Are your teeth sensitive to hot, cold or sweets?

__Yes __ No Do you have dental implants?

__Yes __ No Are you unsatisfied with the appearance of your teeth?

__Yes __ No Do you clench or grind your teeth?

__Yes __ No Do you experience jaw pain or joint clicking?

__Yes __ No Have you had orthodontic treatment?

__Yes __ No Have you ever been treated for gum disease?

__Yes __ No Have you had any head, neck or jaw injuries?

__Yes __ No Have you had excessive bleeding after extractions?

To the best of my knowledge all of the preceding answers are correct. I understand that providing incorrect information can be dangerous to my health. If I have any changes in my health status or medication I shall inform the dentist and staff at the next appointment.

Signature of Patient (or guardian) ____ Date ________________