WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name _____ Soc. Sec. # _____

Address _____

City _____ State _____ ZIP _____ Home Phone _____

Cell Phone _____ Email _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____

Business Email _____ Business Phone _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Email _____

PRIMARY INSURANCE

Person Responsible for Account _____

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different) _____ Home Phone _____

City _____ State _____ ZIP _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____

Business Email _____ Business Phone _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber's # _____

Name(s) of other dependents under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ ZIP _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber's # _____

Name(s) of other dependents under this plan _____

Signature _____ Date _____

UPTOWN
DENTAL

CONSENT

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have a right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature_____ Date _____
Patient, parent or legal guardian

If signed by patient representative, state relationship to patient _____

UPTOWN
DENTAL

CONTACT INFORMATION

We will send your appointment confirmation reminders by text message and/or by email unless you would prefer a telephone call. You will be able to confirm your appointment directly from the email or the text message.

We may send email announcements from the office such as new products or services, special whitening prices, or other promotions. If you wish to receive these notices, we are required to send these by email rather than by text message. We will also post these on our website and Facebook page. If you would like to be added to our email list, please provide us with your email address below.

Visit us online at www.uptowndentalms.com or find us on Facebook at UptownDentalMS.

Name _____

I prefer to be contacted for my appointment confirmations:

- ☐ BY TELEPHONE _____
- ☐ BY TEXT MESSAGE _____
- ☐ BY EMAIL _____

INFORMATION UPDATE

Please fill out this portion if there are any recent changes:

- ☐ NAME _____
- ☐ ADDRESS _____
- ☐ PHONE _____
- ☐ INSURANCE INFORMATION _____

DENTAL HISTORY

Please check any of the following that apply to you:

- ☐ Sensitivity (hot, cold, sweet)
  Where? UR LR UL LL
- ☐ Headaches, ear aches, neck or jaw joint pain
- ☐ Mouth ulcers or cold sores
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen, or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath

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

- ☐ Dentures
- ☐ Partial dentures
- ☐ Braces
- ☐ Gum treatments

Please share the following dates:

Your last cleaning ____/____

Your last oral chancer screening ____/____

Your last complete X-rays ____/____

Name of previous dentist _____

City _____ State _____

Phone Number _____

What is the most important thing to you about your future smile and dental health?

_____

If you could whiten your teeth for a cost anyone would afford, would you do it?

☐ **Do you smoke or use chewing tobacco?**

How much? _____ For how long? _____

If I could change my smile, I would:

- ☐ Make my teeth whiter
- ☐ Make my teeth straighter
- ☐ Close spaces
- ☐ Replace metal fillings with tooth-colored restorations
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

_____

What is the most important thing to you about your dental visit today?

_____

_____

MEDICAL HISTORY

Please check any of the following that apply to you:

- ☐ Allergies (Seasonal)
- ☐ Anemia
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Heart Conditions
- ☐ Heart Murmur
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervousness/Depression
- ☐ Pacemaker
- ☐ Phen Fen (1 month+)
- ☐ Radiation (head/neck)
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other (please list)

_____

_____

For Women Only

- ☐ Birth Control Pills
- ☐ Breastfeeding
- ☐ Pregnant
  1-3 mos, 3-6mos, 6-9mos

Do you have an allergy to any of the following?

- ☐ Aspirin
- ☐ Codeine
- ☐ Erythromycin
- ☐ Other: _____
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Nitrous Oxide
- ☐ Penicillin

What medications are you currently taking?

_____

_____

_____

Are you under a physician's care? For what?

_____

_____

Family Physician _____

Phone Number _____