Welcome

Thank you for selecting our Dental Healthcare team! We strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill out this form completely. If you have questions or need assistance, please ask us.

Personal Information

Name _____Date of Birth _____

If Patient is Minor, Please list all Parents/Guardians_____

SSN _____ Male □ Female □

Address_____City/State/Zip_____

Cell # _____Work# _____ Home# _____

Email _____ Preferred Method of Contact **Voice** □ **Text** □ **Email** □

□ Married □ Single □ Widowed □ Separated □ Divorced □ Minor/Child

Patient Employer _____ Occupation _____

Emergency Contact Name and Phone Number _____

Relation to Patient:_____

How did you hear about us? □ Website □ Google □ Facebook □ Insurance

Who may we thank for your referral? _____ □ Friend □ Doctor □ Other

Dental Insurance Information

Primary Dental Insurance

Insurance Company _____

Name of Insured _____

Relationship to Patient _____ Insured's Birthdate _____SSN_____

Employer_____ Occupation _____

Group # _____ Ins. Co. Phone # _____

Ins. Co. Address _____

Secondary Dental Insurance (If Applicable)

Insurance Company _____

Name of Insured _____

Relationship to Patient _____ Insured's Birthdate _____SSN_____

Employer_____ Occupation _____

Group # _____ Ins. Co. Phone # _____

Ins. Co. Address _____

Medical History

Physician's Name and Phone # _____

Are you currently under a physician's care? □ Yes □ No If yes, please explain. _____

Women Only:	Yes	No
1. Are you pregnant or think you may be pregnant?	□	□
2. Are you nursing?	□	□
3. Are you taking birth control pills?	□	□

● Please list **ALL** medications you are currently taking: _____

_____

● Please list **ALL** medications you are allergic to and their reaction: _____

● Please list **ALL** allergies you have and their reaction: _____

●Please list **ALL** surgeries or operations you have had and dates: _____

_____

● Please list all conditions and/or diseases you have been diagnosed with and dates:_____

_____

● Do you have any Joint Replacements or Implants? □ Yes □ No Date and Area_____

● Have you ever been diagnosed with cancer? □Yes □ No If yes, when and type? _____

● Do you have any type of Heart Problems or Stroke? □ Yes □ No If yes, please describe._____

● Have you ever been diagnosed with Pre-Diabetes or Diabetes? □Yes □No If yes, when. _____

● Have you ever taken an antibiotic premedication before a dental treatment? □ Yes □ No If yes, please provide why.

_____

● Do you have a persistent cough or throat clearing not associated with a known illness? □ Yes □ No

● Do you use tobacco? □ Yes □ No If yes, what type and how often? _____

Please **check all that apply** if you have had or currently have any of the following:

□ AIDS/HIV Positive
□ Anaphylaxis
□ Anemia
□ Anxiety
□ Arthritis/Rheumatism
□ Asthma
□ Chemotherapy
□ Depression
□ Diabetes
□ Epilepsy
□ Fainting
□ Headaches
□ Heart Murmur
□ Heart Attack
□ Hemophilia
□ Herpes
□ Hepatitis
□ High Blood Pressure
□ Jaw Pain
□ Latex Allergy
□ Mitral Valve Prolapse
□ Pace Maker
□ Rapid Weight Loss/Gain
□ Radiation Treatment
□ Rheumatic/Scarlet Fever
□ Shingles
□ STD
□ Spina Bifida
□ Stroke
□ Thyroid Disease
□ Tonsillitis
□ Tuberculosis
□ Ulcer

Dental History

- Reason for Visit? _____
- Former Dentist: _____ When was your last dental visit? _____
- How many times per day do you brush? _____ ● What texture brush do you use? □Soft □Medium □Hard
- Have you ever experienced an adverse reaction during a medical or dental procedure? □Yes □No
  If yes, please explain. _____
- Have you ever had an upsetting experience in a dental office? □ Yes □ No
  If yes, please explain. _____
- Is there anything about having dental treatment that bothers you? □ Yes □ No
  If yes, please explain. _____

Please **check all that apply** if you have had problems with any of the following:

□ Bad breath	□ Biting your lips	□ Sensitivity to Sweets
□ Bleeding gums	□ Biting your cheeks	□ Sensitivity when biting
□ Clicking/Popping Jaw	□ Sores in your mouth	□ Loose teeth
□ Frequent headaches	□ Difficulty chewing	□ Broken teeth
□ Grinding teeth	□ Jaw pain	□ Difficulty chewing
□ Clenching teeth	□ Hot/Cold Sensitivity	□ Food collection between teeth

Please **check** any treatment you have had:

□ Orthodontics (Braces)	□ Oral Surgery	□ Treatment for Gum Disease
□ Scaling and Root Planing	□ Worn a mouth guard at night	

Many of our patients allow family members such as spouse, parents, or others to call and request medical or billing information. Under HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to someone, you MUST sign below. Signing this form will only give information to persons indicated below.

I authorize MATTHEW A TURNER, D.D.S., P.C. to release my medical and/or billing information to the following individuals(s):

1. _____Relation to Patient and Phone Number: _____

2. _____Relation to Patient and Phone Number: _____

3. _____Relation to Patient and Phone Number: _____

Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. While we will work with your insurance company to make sure you get the max benefits that your employer provides for you, your care may go beyond what is covered.

X_____

Signature of patient or parent/guardian (if minor) Date