Edgewater Dental Arts

Patient Information **Today's Date:_____**

Patient Name: _____

Gender: M__ F___ Date of Birth: ____/____/_____ Social Security#: _____

Home Address: _____

Patient Employer: _____

Occupation: _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Email: _____

Spouse Name: _____

Spouse Social Security#_____

Spouse Employer: _____

Emergency Contact Name: _____

Emergency Contact Phone: (_____) _____

Who referred you to our office: Friend/Family*___ Newspaper___ Yellow Pages___ Other___

*Please specify so we can thank them:_____

Insurance Information

Primary Insurance: _____

Group# _____ Phone#_____

Dr. Cutting does not participate with any insurance companies in accepting reduced fees. The responsibility of the insurance is to you and it is your responsibility to see that you are reimbursed properly. As a courtesy to our valued patients, we will file claims for your primary insurance and if needed, we will provide you with all information necessary to file your claim with your secondary insurance. Fees for services provided to insured patients are our usual and customary fees charged to all patients for similar services. Your insurance company may base its allowance on their own fixed fee schedule. The amount of the fee paid may therefore be different than the percentage listed in your benefit booklet. We will do our best to see that you receive all of the benefits due to you.

I understand that the responsibility for payment for professional services and products provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless written financial arrangements have been made prior to start of treatment. In the event of default, I promise to pay any collection costs and attorney fees as may be required to effect collection.

_____ Date:_____

Signature of Responsible Party

(Please complete the back of this form)

Tell us more:

Why have you made this dental appointment?_____

_____

Why did you leave the office of your previous dentist?

_____

Please check one box in each section:

My mouth is: _____ Very Comfortable

_____ Moderately Comfortable

_____ Uncomfortable

Choose one:
_____I think the appearance of my smile is excellent
_____I am satisfied with the appearance of my smile
_____I would like to change my smile
_____I am unconcerned about the appearance of my mouth

Choose one:
_____I will do whatever I must to keep my teeth
_____I want to keep my teeth but only within a certain budget of time and money
_____I am indifferent about keeping my teeth

Choose one:
_____I have always done the dental treatment that was recommended to me
_____I usually do what dental treatment was recommended to me
_____I have not done what dental treatment was recommended to me
_____I have not had dental treatment recommended to me

Choose one:
_____I put dental care for myself and family high on my priority list
_____I put dental care low on my list
_____I have never considered where I put dental care

I think my present state of dental health is: _____ Excellent
_____Good
_____Fair

Obstacles I see to having excellent dental care for myself. If you select more than one of the following, please number them in order of significance with #1 being that which is most significant for you at this time:

_____I see no obstacles
_____Time away from work or other obligations
_____Fear of pain, surgery or injections
_____Fear due to past dental experiences
_____The cost of the treatment
_____Other Please explain: _____

Edgewater Dental Arts
Medical History

Patient Name: _____ Date: _____

Preferred Pharmacy: _____ Phone#:_____

Physician's Name: _____ Phone#:_____

Medications (please include any pre-medication):

Allergies:

Yes	No		Yes	No	
		Aspirin			Latex
		Codeine			Metals (ex. Nickel, Stainless Steel)
		Dental Anesthetics			Penicillin
		Erythromycin			Tetracycline
		Jewelry			Other:

Do you smoke or use tobacco? Yes No

If female, please answer the following:

Are you taking Birth Control Pills? Yes No

Are you pregnant? Yes No if yes, # of weeks: _____

Are you nursing? Yes No

Conditions:

Y	N		Y	N		Y	N	
☐	☐	Abnormal Bleeding	☐	☐	Frequent Headaches	☐	☐	Radiation Therapy
☐	☐	Alcohol Abuse	☐	☐	Glaucoma	☐	☐	Seizures
☐	☐	Allergies	☐	☐	HIV+ AIDS	☐	☐	Shingles
☐	☐	Anemia	☐	☐	Heart Attack	☐	☐	Sickle Cell Disease
☐	☐	Angina Pectoris	☐	☐	Heart Condition	☐	☐	Sinus Problems
☐	☐	Arthritis	☐	☐	Heart Murmur	☐	☐	Stroke
☐	☐	Artificial Bones/Joints	☐	☐	Heart Surgery	☐	☐	Thyroid Problems
☐	☐	Artificial Heart Valve	☐	☐	Hemophilia	☐	☐	Tuberculosis
☐	☐	Asthma	☐	☐	Hepatitis A	☐	☐	Ulcers
☐	☐	Blood Transfusion	☐	☐	Hepatitis B			
☐	☐	Cancer – Chemotherapy	☐	☐	Herpes			
		Cancer type:_____	☐	☐	High Blood Pressure			
☐	☐	Colitis	☐	☐	Kidney Problems			
☐	☐	Congenital Heart Defect	☐	☐	Liver Disease			
☐	☐	Diabetes	☐	☐	Low Blood Pressure			
☐	☐	Difficulty Breathing	☐	☐	Migraines			
☐	☐	Drug Abuse	☐	☐	Mitral Valve Prolapse			
☐	☐	Emphysema	☐	☐	Osteoporosis			
☐	☐	Epilepsy	☐	☐	Pace Maker			
☐	☐	Fainting Spells	☐	☐	Pain in Jaw Joints			
☐	☐	Fever Blisters	☐	☐	Psychiatric Problems			

Other conditions not listed that we should know about:

I certify that the information listed here is accurate to the best of my knowledge (please sign below):