Adult Patient Information Form

BACKGROUND INFORMATION

Date ______________________________

Name ______________________________ I preferred to be called ______________ ☐ M ☐ F
(First) (MI) (Last)

Home Address ______________________________
(Street/P.O. Box) (City) (State) (ZIP)

Phone ______________________________
(Home) (Work) (Cell)

Email Address ______________________ How did you find out about us? ______________

Birthdate _____/_____/_____ Social Security # ______________

Best way to reach you? ______________ Whom may we thank for referring you? ______________

Other family members seen by us? ______________________________

Employer ______________ Occupation ______________ How long? ________

Employer's Address ______________________________
(Street/P.O. Box) (City) (State) (ZIP)

☐ Single ☐ Married ☐ Widowed ☐ Divorced/Separated

If Married, Name of Spouse ______________________________
(First) (MI) (Last)

Birthdate _____/_____/_____ Social Security # ______________

Employer ______________ Work Phone ______________

Emergency Contact Name ______________ Relationship ______________

Home Address ______________________________
(Street/P.O. Box) (City) (State) (ZIP)

Phone ______________________________
(Home) (Work) (Cell)

PERSON RESPONSIBLE FOR ACCOUNT ☐ Same as above

Name ______________________________ Relationship ______________
(First) (MI) (Last)

Phone ______________________________
(Home) (Work) (Cell)

Social Security # ______________ Driver's License # ______________

Employer ______________________________

Billing Address ______________________________
(Street/P.O. Box) (City) (State) (ZIP)

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE **Please present insurance card to front desk staff**

Dental Coverage? ☐ Y ☐ N Medical Coverage? ☐ Y ☐ N Orthodontic Coverage? ☐ Y ☐ N

Insured's Name ______________ ID # ______________

Relationship to Patient ______________ Group # (Plan, Local, or Policy #) ______________

Insurance Company ______________ Insurance Company Phone ______________

Insurance Company Address ______________________________
(Street/P.O. Box) (City) (State) (ZIP)

Insured's Employer ______________________________

Employer's Address ______________________________
(Street/P.O. Box) (City) (State) (ZIP)

SECONDARY INSURANCE **Please present insurance card to front desk staff**

Dental Coverage? ☐ Y ☐ N Medical Coverage? ☐ Y ☐ N Orthodontic Coverage? ☐ Y ☐ N

Insured's Name ______________ ID # ______________

Relationship to Patient ______________ Group # (Plan, Local, or Policy #) ______________

Insurance Company ______________ Insurance Company Phone ______________

Insurance Company Address ______________________________
(Street/P.O. Box) (City) (State) (ZIP)

Insured's Employer ______________________________

Employer's Address ______________________________
(Street/P.O. Box) (City) (State) (ZIP)

You are responsible for paying your account balance and for informing us of any changes in your insurance. Thank you.

DENTAL HISTORY

Reason for seeing the dentist today: ____________________

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Are you currently in pain? ☐ Y ☐ N Do you require antibiotics before dental treatment? ☐ Y ☐ N

Have you experienced problems associated with previous dental work? ☐ Y ☐ N

Have you realized pain or discomfort in your jaw joint (TMJ/TMD)? ☐ Y ☐ N

Do you floss daily? ☐ Y ☐ N Do you brush daily? ☐ Y ☐ N

Type of bristles on toothbrush? ☐ Hard ☐ Medium ☐ Soft How long do you use your toothbrush before replacing it? ____________

Do you use anything in addition to brushing and flossing? ☐ Y ☐ N If yes, please indicate what? ____________

Would you like fresher breath? ☐ Y ☐ N Would you like whiter teeth? ☐ Y ☐ N

Do your gums ever bleed? ☐ Y ☐ N Do your gums ever itch? ☐ Y ☐ N

Do you now or have you had periodontal disease? ☐ Y ☐ N Do you have mobility in your teeth? ☐ Y ☐ N

Have you been informed of having any extra teeth? ☐ Y ☐ N Do you have your wisdom teeth? ☐ Y ☐ N

Are your teeth sensitive? ☐ Y ☐ N If yes, to what? ____________

Previous Dentist, if applicable ____________ Date of Last Visit ____________

Why did you leave your previous dentist? ____________

What have you liked most and/or least about any dentist you have ever seen? ____________

Are you happy with the way your smile looks? ☐ Y ☐ N If no, what would you change? ____________

MEDICAL HISTORY

Current Physician ____________ Date of Last Visit ____________

Address ____________
(Street/P.O. Box) (City) (State) (ZIP)

Phone ____________ Current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Y ☐ N Please explain: ____________

Do you smoke or use tobacco in any form? ☐ Y ☐ N Have you ever taken Fosamax or any other biophosphonate? ☐ Y ☐ N

Are you allergic to any of the following?

Aspirin	☐ Y	☐ N	Dental Anesthetics	☐ Y	☐ N	Latex	☐ Y	☐ N	Sulfa Drugs	☐ Y	☐ N
Barbituates	☐ Y	☐ N	Erythromycin	☐ Y	☐ N	Penicillin	☐ Y	☐ N	Tetracycline	☐ Y	☐ N
Codeine	☐ Y	☐ N	Jewelry/Metals	☐ Y	☐ N	Sedatives	☐ Y	☐ N	Other	☐ Y	☐ N

Please explain: ____________

FOR WOMEN: Are you currently taking birth control pills? ☐ Y ☐ N

Are you pregnant? ☐ Y ☐ N ☐ Unsure If yes, approximate week number: ________ Are you nursing? ☐ Y ☐ N

Please circle any of the following you are currently taking:

Acetaminophen	Aspirin	Cold Remedies	Nitroglycerin	Thyroid Medicine
Antibiotics	Blood Thinners	Digitalis/Heart Medication	Recreational Drugs	Tranquilizers
Antihistimines	Blood Pressure Medication	Insulin/Diabetes Drugs	Steroids/Cortisone	Other (please specify) ____________

Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins, or minerals not listed above? ☐ Y ☐ N

If yes, please explain: ____________

Please circle any of the following medical issues you currently experience *or* have previously experienced:

Abnormal Bleeding	Cancer	Epilepsy	Heart Surgery	Liver Disease	Radiation Treatment	Stroke
Alcohol Abuse	Chemotherapy	Fainting Spells	Hemophilia	Low Blood Pressure	Rheumatic Fever	Thyroid Problems
Anemia	Colitis	Fever Blisters	Hepatitis	Lupus	Scarlet Fever	Tonsilitis
Arthritis	Congenital Heart Defect	Glaucoma	Herpes	Mitral Valve Prolapse	Seizures	Tuberculosis (TB)
Artificial Bones/Joints	Diabetes	Hay Fever	High Blood Pressure	Osteoporosis/Paget's Disease	Shingles	Ulcers
Artificial Valves	Difficulty Breathing	Headaches	HIV+/AIDS	Pacemaker	Sickle Cell Disease	Venereal Disease
Asthma	Drug Abuse	Heart Attack	Hospitalized for Any Reason	Persistent Cough	Sinus Problems	
Blood Transfusion	Emphysema	Heart Murmur	Kidney Problems	Psychiatric Issues	Steroid Therapy	

Please indicate any other medical condition(s) not indicated above: ____________

This information is correct to the best of my knowledge. It will be held in the strictest confidence, and it is my responsibility to inform Morningside Dental of any changes in my medical status. I authorize the staff of Morningside Dental to perform the necessary dental services I may need. My method of payment will be ____________.

____
Signature Date

Payment is due at time of service.

I certify that I am covered by____________ Insurance Company, and I assign directly to Dr.____________ all insurance benefits otherwise payable to me. I understand I am responsible for payment of services rendered and responsible for paying any co-payment and deductible my insurance does not cover. I authorize Morningside Dental to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions, whether manual or electronic.

____
Signature Date