# Welcome to our practice!

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to call us.

Today's Date: _____/_____/ _____

Whom may we thank for referring you? _____

## PATIENT INFORMATION

First Name: _____ Last Name: _____ Sex: ❑ Female ❑ Male

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____
Minor Child? ❑ Yes ❑ No

❑ Married ❑ Widowed ❑ Single ❑ Separated ❑ Divorced ❑ Partnered for _____years

Address: _____City_____ State_____ Zipcode_____

Home Phone Number: ( )_____ Cell Phone Number: ( )_____

Email Address: _____@_____ Preferred Method of Contact:
❑ Home ❑ Cell ❑ Email

Employer/School: _____ Employer/School Phone: ( )_____

Spouse/Parent's Name: _____ Employer: _____ Work Phone: ( )_____

Emergency Contact Name: _____ Relationship:_____ Phone Number: ( )_____

## DENTAL INSURANCE INFORMATION

Name of Insured: _____Relation to Patient: _____

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Address: _____ City_____ State_____ Zipcode_____

Home Phone Number: ( )_____ Cell Phone Number: ( )_____

Email Address: _____@_____ Preferred Method of Contact:
❑ Home ❑ Cell ❑ Email

Insurance Company: _____ Insurance Phone: ( ) _____

Insurance Address: _____ City _____ State _____ Zipcode: _____

Employer: _____ Subscriber ID Number: _____ Group Number: _____

Secondary Dental Insurance: ❑ Yes ❑ No If yes: Subscriber ID Number: _____Group Number: _____

Name of Insured: _____ Relation to Patient: _____

Insurance Company: _____ Insurance Phone: (  ) _____

Insurance Address: _____ City _____ State _____ Zipcode: _____

## DENTAL HISTORY

Reason for Today's Visit: _____ Date of Last Dental Visit: _____/_____/_____

Former Dentist: _____ Date of Last Dental X-rays:_____/_____/_____

Address: _____ City_____ State_____ Zipcode_____

Check (☑) if you have had problems with any of the following:

❑ Bad breath ❑ Bleeding gums ❑ Clicking or popping jaw ❑ Food collection between teeth

❑ Grinding teeth ❑ Loose teeth or broken fillings ❑ Periodontal treatment ❑ Sores/growths in your mouth

❑ Sensitivity to hot ❑ Sensitivity to cold ❑ Sensitivity to sweets ❑ Sensitivity when biting

How often do you brush? _____ How often do you floss? _____

## MEDICAL HISTORY

Family Physician: _____ Phone Number (  )_____ Currently Under Physician's Care: ❑ Yes ❑ No

Have you recently had any serious illnesses or surgeries? ❑ Yes ❑ No If yes, describe:_____

Do you take any bisphosphonate (Fosamax) medications or blood thinners? ❑ Yes ❑ No If yes, name:

_____

Please list current medications:

_____

Are you allergic to any medications, substances, or latex? ❑ Yes ❑ No If yes, name:

_____

Have you been vaccinated for COVID-19 ? ❑ Yes ❑ No Have you had to COVID-19 booster vaccine ? ❑ Yes ❑ No

Check (☑) if you have had problems with any of the following:

❑ A.I.D.S./HIV Positive ❑ Cough, Persistent ❑ Hemophilia ❑ Pacemaker

❑ Alcoholism ❑ Diabetes ❑ High Blood Pressure ❑ Psychiatric Care

❑ Allergies ❑ Excessive Bleeding ❑ Hip/Joint Replacement ❑ Radiation Treatment

❑ Anemia ❑ Epilepsy ❑ HPV ❑ Rheumatic Fever

❑ Asthma ❑ Glaucoma ❑ Jaundice ❑ Rheumatism/Arthritis

❑ Blood Disease ❑ Hay Fever ❑ Jaw Pain ❑ Scarlet Fever

❑ Bone Disease ❑ Headaches ❑ Kidney Disease ❑ Sinus Problems

❑ Cancer ❑ Head Injuries ❑ Kidney Dialysis ❑ Stomach Ulcers

❑ Chemical Dependence ❑ Hearing Impaired ❑ Lupus ❑ Stroke

❑ Chest Pain ❑ Heart Disease ❑ Low Blood Pressure ❑ Thyroid Disease

❑ Circulatory Problems ❑ Heart Valve, Murmur ❑ Mitral Valve Prolapse ❑ Tuberculosis

❑ Convulsions/Seizures ❑ Hepatitis/Liver Disease ❑ Neck & Back Problems ❑ Venereal Disease

❑ Cortisone Treatments ❑ Nervous Disorders ❑ COVID-19 ❑ Other: _____

*Women:* Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

## AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to Dr. Darren Chugg all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named dentist may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

**Patient/Parent/Guardian Signature:** _____ **Date:** _____/_____/_____