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GENERAL INFORMATION

Dr.
 Mr.
 Mrs.
 Miss, MS. _____ **Birth Date** _____
Last First Middle

How would you like to be addressed in our office? (Title and/or Name) _____

Residence Address _____ (____) _____
Number Street City State Zip Code Telephone

Cell Phone (____) _____ **Work Phone** (____) _____ **Ext.** _____

E-Mail Address _____

Marital Status _____ **Social Security Number** _____

Occupation _____ **Employer** _____

Address of Employer _____ (____) _____
Number Street City State Zip Code Telephone

In case of an emergency, please contact _____

Relationship to Patient _____ **Telephone Number** (____) _____

If patient is a minor, who is legally responsible? _____

Address _____ (____) _____
Number Street City State Zip Code Telephone

By whom were you referred? _____

DENTAL INSURANCE INFORMATION

Name of Dental Insurance Plan _____ **Group Number** _____

Employee _____ **Employee's Social Security No.** _____

Employee's Birth Date _____ **Relationship to Employee** _____

MEDICAL HISTORY

Family Physician _____ **Specialty** _____

Address _____ (____) _____
Number Street City State Zip Code Telephone

Additional Physician _____ **Specialty** _____

Address _____ (____) _____
Number Street City State Zip Code Telephone

Height _____ **Weight** _____ **Age** _____ **Date of last complete medical examination** _____

DENTAL HISTORY

Previous Dentist _____ **Period of treatment** _____ **Specialty** _____

Address _____ (_____) _____
Number Street City State Zip Code Telephone

Other Dentist _____ **Period of treatment** _____ **Specialty** _____

Address _____ (_____) _____
Number Street City State Zip Code Telephone

Last dental visit _____ **Last full mouth X-ray** _____ **Last complete dental exam** _____

What is your immediate dental concern? _____

Please encircle **YES** or **NO**. If YES, please fill in the details.

- Yes No** Are you presently in any dental pain? _____
- Yes No** Have you experienced any unfavorable reaction to dentistry? _____
What? _____
- Yes No** Have you lost any teeth? From what cause? _____
- Yes No** Have you ever had orthodontic treatment? When? _____
- Yes No** Do you have any growths or swellings in your mouth? How long have they existed? _____
- Yes No** Do you have any difficulty in swallowing? _____
- Yes No** Do your gums bleed when brushing your mouth? _____
- Yes No** Do you avoid brushing any part of your mouth? Why? _____
- Yes No** Have you ever been told you have pyorrhea? When? _____
- Yes No** Is any part of your mouth sensitive to temperature, pressure or food or drink? What? _____
- Yes No** Do you have a burning sensation of your mouth? _____
- Yes No** Have you ever had a bad reaction to a dental anesthetic? When? _____
- Yes No** Does food catch between your teeth? _____
- Yes No** Do you have any pain or soreness around your eyes or ears or other parts of your face?
When? _____
- Yes No** Are you aware of stiff neck muscles? How often? _____
- Yes No** Do you ever awaken with an awareness of your teeth or jaws? How often? _____
- Yes No** Are you aware of clenching your teeth during your daytime hours? How often? _____
- Yes No** Have you ever been told you grind your teeth during sleep? How often? _____
- Yes No** Have you ever been told that you snore while sleeping? How often? _____
- Yes No** Are you aware of your jaw clicking or popping while eating or yawning? How often? _____
- Yes No** Do you have difficulty in opening your mouth widely? _____
- Yes No** Do you have "tension" headaches? How often? _____
- Yes No** Do you have an unpleasant taste or odor in your mouth? _____
- Yes No** Are you dissatisfied with your teeth and their appearance? _____
- Yes No** Do any members of your family, including your parents, wear dentures? _____
- Yes No** Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Patient Name: _____

Drs. Drockton/Rodriquez appreciate the confidence you have shown in choosing us to provide for your dental care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees.

As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. You will be responsible for your balance in full.



I understand that the responsibility for payment for professional services 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 and signed by me. I understand that I will be responsible for any charges incurred by NOT providing the most current, correct insurance information to Drs. Drockton/Rodriquez. In the event of default, I promise to pay interest on the indebtedness, together with any collection costs and attorney fees as may be required to effect collection, as well as pay any fees associated with returned checks.

I have read the above policy regarding my financial responsibility to Drs. Drockton/Rodriquez, for providing dental services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Drs. Drockton/Rodriquez.

**Patient /
Legal Guardian Signature** _____ **Date** _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Drs. Drockton/Rodriquez to release dental information acquired in the course of my examination or treatment, to my insurance company, or other physicians required to participate in my care.

**Patient /
Legal Guardian Signature** _____ **Date** _____

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY POLICY

I acknowledge that I have received a copy of Drs. Drockton/Rodriquez Privacy Policy.

**Patient /
Legal Guardian Signature** _____ **Date** _____

CANCELLATION / NO SHOW POLICY

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call, if possible, 48 hours prior to your appointment.

I understand that I may be charged a service charge for a no show. I also understand that a no show for three appointments or cancellations of a total of four consecutive appointments, may result in a discharge from further dental care.

**Patient /
Legal Guardian Signature** _____ **Date** _____