CONTACT

Patient's Name: _________________________________ Preferred Name:__________

Age: _____ Birthdate:___/____/_____ Gender: ________

Address:____

City:_________________________ State:_____ Zip:_____________

Home Phone: __________________Cell Phone: __________________Work Phone:_________________

SS#:__________________________ Marital Status: ☐ Single ☐ Married ☐Divorced ☐Widowed

Employer:_____________________ Employer's Phone Number: ___________________________

Spouse's Name:________________________________ Spouse's Cell: ___________________________

Emergency Contact: _______________________ Relation:___________ Phone Number:_____________

Preferred Pharmacy:_________________________ **How did you hear about us?** ___________________

INSURANCE

Do you have dental insurance? ☐Yes ☐ No If YES, Insurance Carrier's Name: _____________________

Insurance ID #____________________Group #______________Subscriber's Name:_________________

Phone:________________ Relation to Patient:_______________ Subscribers SS#__________________

Subscriber's Date of Birth:___/_____/_______ Phone Number of Insurance Company:______________

Insurance Carrier Address, City, State, Zip: ____

Secondary Dental Insurance// Name of Company:___________________ ID#:_____________

Subscriber's Name:______________ Subscriber's Date of Birth:___/____/_____ Subscribers

SS#_________________ Group #:__________ Address of Company:_______________________________

Would you like to receive appointment reminders via text message or email? ☐Yes ☐ No

If YES, who is your carrier? (Verizon, Sprint etc) ________________ Email:_________________________

FINANCIAL OBLIGATION: OFFICE POLICY REGARDING INSURANCE: Your dental insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. The responsibility of payment ultimately lies with the patient, not the insurance company. As a courtesy, we will file a claim on your behalf**. I understand that I am required to pay my "Estimated Patient Portion" and any deductible due, to Fuller Associates Family Dentistry at the time of my visit**. Failure to provide our office with all the information necessary to file your insurance claim will require full payment at the time of service. Any portion of the treatment that the insurance does not cover is the patient's responsibility. A statement will be sent to the patient with any balance not paid by insurance. I hereby authorize the release of any dental information that is needed to file my insurance. I consent to treatment for myself/family under 18 years old. I have read the following statements and understand that I am responsible for payment in full after 45 days of my treatment, regardless of any delay in payment(s) by my insurance company. I understand that a 1.0% per month late charge may be added to my account for any overdue balance that is my responsibility.

Type Name/Signature: ____ Date:____/____/_______

Medical History NAME: ________________________________

In order for us to provide you with the safest and best possible care, please complete these questions thoroughly.

Have you taken any prescription drugs during the last 6 months? Please list with dosage and frequencies

____

____

Have you ever been told to take antibiotics prior to dental treatment? If yes, why? _______________

Are you taking any over the counter medications or herbal supplements? Please provide a list.

____

Do you have any allergies or are made sick by any medication? Please provide a list and the side effects.

____

Have you had any surgeries and/or hospitalizations?

____

Have you ever had excessive bleeding requiring special treatment? _____________________________

Have you ever taken drugs by mouth or injection to strengthen bone for conditions such as osteoporosis, multiple myeloma, Paget's disease, breast or prostate cancer? Please list which one and when was the last time taking the prescription/ injection______________________________________

Use of alcohol: ☐ Yes ☐ No // ☐ Daily ☐ Weekly ☐ Monthly Use of recreational drugs: ☐ Yes ☐No
Do you use tobacco? ☐ Yes ☐ No What type and how much per day? ___________________________

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE AT THE PRESENT OR HAVE HAD IN THE PAST:

☐ Low Blood Pressure
☐ High Blood Pressure
☐ Heart Disease/Attack
☐ Angina Pectoris
☐ Artificial Heart Valve
☐ Heart Failure
☐ Heart Pacemaker
☐ Stroke
☐ Kidney Problems
☐ Sexually Transmitted Diseases
☐ Tuberculosis

☐ Acid Reflux
☐ Ulcers
☐ Liver Failure
☐ Hepatitis/ Jaundice
☐ Diabetes Type I or II
☐ Thyroid/ Gland Problems
☐ Seizures/ Epilepsy
☐ Allergies/ Sinus Trouble
☐ Asthma/ Bronchitis
☐ Respiratory/Breathing Issues
☐ Emphysema/ COPD
☐ Chemotherapy
☐ Cancer/Tumors

☐ Radiation Treatment
☐ HIV/AIDS
☐ Anemia
☐ Leukemia
☐ Bruise/ Bleed Easily
☐ Osteoporosis
☐ TMJ/Jaw Problems
☐ Arthritis
☐ Joint Replacements
☐ Sleep Apnea
☐ Scarlet Fever
☐ Excessive Daytime Sleepiness

FEMALES:
Are you pregnant now? ☐ Yes ☐ No // Practicing birth control? ☐ Yes ☐ No // Plan to become pregnant? ☐ Yes ☐ No

Dental History

Answers to these questions help us provide safe and effective dental care personalized to your individual needs. All information is kept strictly confidential.

ARE ANY OF YOUR TEETH SENSITIVE TO:	YES	NO
Hot or cold?	☐	☐
Sweets?	☐	☐
Biting or chewing?	☐	☐
Have you noticed any mouth odors or bad taste?	☐	☐
Do you frequently get cold sores?	☐	☐
Do you frequently get oral ulcers?	☐	☐
Do your gums bleed or hurt?	☐	☐
Have you noticed any loose teeth?	☐	☐
Have your teeth shifted over the years?	☐	☐
Does food tend to become caught in your teeth?	☐	☐

DO YOU:		
Clench/ grind your teeth while awake or asleep? Have tired jaws in the morning?	☐	☐
Have a hard time opening wide?	☐	☐
Mouth breathe while awake or asleep?	☐	☐
Hold foreign objects with your teeth (i.e. pencils, nails)? Chew ice often?	☐	☐

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING:		
Clicking or popping of the jaw?	☐	☐
Pain in the jaw joint area near the ear?	☐	☐
Difficulty in opening or closing your mouth?	☐	☐
Headaches, neck aches, or shoulder aches frequently?	☐	☐
Sore muscles in the neck or shoulders?	☐	☐

I WOULD LIKE TO LEARN MORE ABOUT:

☐ Orthodontics ☐ Cosmetic Dentistry ☐ Sedation Dentistry ☐ Implants
☐ Whitening ☐ Bridges ☐ Veneers ☐ Dentures ☐ Other ____________________________________

When was your last dental visit? ______/______/______ Last dental x-rays?______/_______/_______

Name of last dentist ______________________________
How often do you brush your teeth?_______ How often do you floss?________

What other dental aids do you use? (electric toothbrushes, Waterpik water flosser, Soft Picks)
____
Do you have any dental problems that you are aware of now? If yes, please describe.

____
Do you feel nervous about dental treatment? If yes, what is your biggest concern?
____

UPDATE SECTION: (*only complete when instructed*) By signing your initials, you herby verify that you updated your medical history with Fuller Associates and provided us with the most accurate information regarding your health.