Holler Family Dentistry

WELCOME

1 ABOUT YOU

Today's Date:____/____/____ File #:_____

Patient Name:_____
LAST FIRST MI

What You Prefer To Be Called:_____ ☐Male ☐Female

Birthdate:___/___/___ Age:_____ SS#:_____

Mailing Address:_____

CITY STATE ZIP

Home Phone #:_____

Work Phone #:_____ Ext:_____

Other Phone #s:_____

E-mail Address:_____

Referred By:_____

Employer:_____ How Long?_____

Employer's Address:_____

CITY STATE ZIP

Occupation:_____

Status: ☐Minor ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Spouse's Name:_____

Do you have children? ☐Yes ☐No How many?_____

2 INSURANCE INFO

Primary Dental Insurance

Co. Name:_____

Address:_____

CITY STATE ZIP

Phone #:_____

Insured's SS#:_____

Group # (Plan, Local, or Policy #):_____

Insured's Name:_____

Relation:_____ Date of Birth:____/____/____

Insured's Employer_____

Secondary Dental Insurance

Co. Name:_____

Address:_____

CITY STATE ZIP

Phone #:_____

Insured's SS#:_____

Group # (Plan, Local, or Policy #):_____

Insured's Name:_____

Relation:_____ Date of Birth:____/____/____

Insured's Employer_____

3 ACCOUNT INFO

Person ultimately responsible for account

Name:_____

Relation:_____

Billing Address:_____

CITY STATE ZIP

SS #:_____

Drivers License #:_____

Work Phone #:_____

Payment method: ☐Cash ☐Check

_____ ____/____

☐Credit Card - Enter card # above (if accepted)

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid for by my insurance company (if offered at this office).
Initials

4 IN EVENT OF EMERGENCY

Who should we contact?_____

Relation:_____

Home Phone #:_____

Work Phone #:_____

Who is your Medical Doctor?_____

M.D.'s Phone #:_____

PLEASE CONTINUE ON BACK

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DENTAL INFORMATION

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation

Are you in pain? ☐ No ☐ Yes How long? _____

Please indicate ☑ any of the following problems:

☐ Discomfort, clicking or popping in jaw. ☐ Lost/Broken Filling(s) ☐ Stained teeth
☐ Red, swollen or bleeding gums. ☐ Teeth grinding ☐ Locking Jaw
☐ Sensitive tooth, teeth or gums. ☐ Ringing in Ears ☐ Bad breath
☐ Blisters/Sores in or around the mouth. ☐ Broken/Chipped tooth
☐ Other: _____

Do you require pre-medication? ☐ Yes ☐ No ☐ Don't know

Previous Dentist: _____ (_____) _____
Name Phone#

Last Dental exam: _____/_____/_____ Last Dental X-rays: _____/_____/_____

Times a day you brush? _____ Times a week you floss? _____

What type of tooth brush bristles do you use? ☐ Soft ☐ Medium ☐ Hard

How would you rate you smile? ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

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MEDICAL HISTORY

Are you taking any of the following medications? ☐ Nerve pills ☐ Pain killers (including aspirin)
☐ Muscle relaxers ☐ Stimulants ☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Other(s) _____

Do you have or ever had any of the following diseases or medical conditions?

Y N Heart Attack / Stroke	**Y N** Kidney Problems	**Y N** Cancer/Tumors	**Y N** Chemotherapy
Y N Heart Surg./Pacemaker	**Y N** Liver Problems	**Y N** Shingles	**Y N** Asthma
Y N Heart Murmur	**Y N** Respiratory Problems	**Y N** Hepatitis	**Y N** Difficulty Breathing
Y N Rheumatic Fever	**Y N** Sinus Problems	**Y N** HIV+/AIDS/ARC	**Y N** Diabetes/Hypoglycemia
Y N Mitral Valve Prolapse	**Y N** Stomach Problems/Ulcers	**Y N** Arthritis/Rheumatism	**Y N** Leukemia
Y N Artifical Valves	**Y N** Psychiatric Problems	**Y N** Artificial Bones/Joints	**Y N** Anemia
Y N Heart Disease	**Y N** Venereal Disease	**Y N** Emphysema	**Y N** High/Low Blood Pressure
Y N Congenital Heart Defect	**Y N** Alcohol/Drug Abuse	**Y N** Fainting/Seizures/Epilepsy	**Y N** Bleeding Problems
Y N Chest Pains	**Y N** Tuberculosis TB	**Y N** Severe/Frequent Headaches	**Y N** Glaucoma
Y N Scarlet Fever	**Y N** Jaw Problems TMJ/TMD	**Y N** Frequent Neck Pain	**Y N** Back Problems

Please list any other medical condition(s) you have or ever had: _____

_____

Are you allergic to any of the following? ☐ Latex ☐ Penicillin/Amoxicillin ☐ Tetracycline ☐ Aspirin
☐ Dental Anesthetics ☐ Others: _____

Do you use tobacco? ☐ No ☐ Yes/How used? _____ How much? _____ How long? _____

Please rate your general health from 1-10: _____ Do you wear contact lenses? ☐ Yes ☐ No

Have you ever taken the drug Phen-fen and or Redux? ☐ Yes ☐ No

For women: Are you taking Birth Control pills? ☐ Yes ☐ No How many children have **you** had? _____

Are you Pregant? ☐ No ☐ Yes/How long? _____ Are you nursing? ☐ Yes ☐ No

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date _____/_____/_____
☐ Adult Patient ☐ Parent or Guardiant ☐ Spouse

UPDATE
(OFFICE USE)

Initials _____ Date ___/___/___
Comments

Initials _____ Date ___/___/___
Comments

Initials _____ Date ___/___/___
Comments