Welcome to TLC Dental Care

Where Healthy Teeth Create Beautiful Smiles!

Today's Date: _____
Last Name: _____ First Name: _____ Nickname: _____
Middle Name, Title: _____ Home Phone #: _____
Address: _____ Work #: _____
City: _____ State: _____ Zip: _____ Cell #: _____

INFO

Male / Female **Marital**: Single / Married / Partnered / Divorced **SSN**: _____
Date of Birth: _____
How did you learn about our office?
Referral-Name: _____
Mailing / Yellow Pages Book / Internet Search Word_____

INSURANCE

Primary Dental Insurance Co: _____
Name of insured: _____
Your relation to the insured: _____
Insured's Birthdate:_____Group #:_____
Patient insurance ID# or SSN: _____

Secondary Dental _____
Name of insured:_____
Your relation to the insured: _____
Insured's B/D:_____Group #:_____
Patient insurance ID# or SSN: _____

RECALL

Hours Available: _____
Days Available: _____
Last Cleaning Date: _____

NOTES

Status: Retired / Full Time Employed / Part Time Employed / Full Time Student / Part Time Student
Employer/School Information: _____

Preferred Pharmacy: _____ Location: _____

CONTACT

Email: _____

Emergency Contact: _____Phone: _____

Dental History

Why have you come to the dentist today?

_____

Are you having any dental problems?

_____

Previous dentist name_____Location/Phone:_____
Have you had any problems with your jaws or jaw joints? Y / N
Circle products in your diet: Soda / Mints / Candy / Dessert / Coffee / Gum / Tea / Popcorn / Ice / Chips
Do you snack between meals? Y / N

Medical History

GENERAL

Physician: _____ Location/Phone: _____

Prescription or Non Prescription medications or recreational drugs:

_____

_____

_____

_____

Have you ever taken bisphosphonates? eg. Fosamx, Prolia, Boniva or Reclast Y / N

Allergies: Aspirin, Codeine, Dental Anesthetics, Erythromycin, Jewelry, Latex, Metals, Penicillin, Tetracycline

Other: _____

Do you smoke or use tobacco/marijuana? Y / N How Much? _____

For Women only… Are you taking Birth Control? Y / N

Are you pregnant? Y / N ___Weeks

Are you nursing? Y / N

Office use:

BP_____HR_____

_____

_____

_____

CONDITIONS

Cicle any of the following that apply…

Y N Anemia	Y N Difficulty Breathing	Y N Hemophilia	Y N Shingles
Y N Arthritis	Y N Drug/Alcohol Abuse	Y N Hepatitis	Y N Sickle Cell
Y N Artificial Bones/Joints	Y N Emphysema	Y N High/Low Blood Pressure	Y N Sinus Problems
Y N Asthma	Y N Epilepsy/Seizures	Y N Hospitalizations	Y N Tuberculosis
Y N Blood Transfusions	Y N Fever Blisters/Herpes	Y N Kidney Problems	Y N Ulcers/Colitis
Y N Cancer/Chemotherapy	Y N HIV+/AIDS	Y N Mitral Valve	Y N Venereal Disease
Y N Congenital Heart	Y N Heart Attack/Stroke	Y N Psychiatric Problems	
Y N Depression	Y N Heart Murmur	Y N Rheumatic Fever	
Y N Diabetes	Y N Heart Surgery	Y N Severe Headaches	

Do you have any other conditions/problems not covered above? If yes, describe below.

_____

_____

_____

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status/insurance status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____ Date _____ Doctor review_____

Patient Signature

Signature On File

I hereby authorize TLC Dental Care to affix my signature to any insurance claims or documents as related to dental care for myself or my dependants. I hereby authorize payment of dental benefits otherwise payable to me directly to TLC Dental Care. I agree to be responsible for all charges for dental services not covered by my dental benefit plan. I consent to the use and disclosure of my protected health information to carry out payment activities in connection with insurance claims.

_____ Date _____

Patient Signature