Welcome To Our Practice

YOUNG ADULT

Tell us about you:

Today's Date: _____

Name: _____
Last First MI

Nickname: _____ Male ___ Female ___

Birthdate: ____/____/____ Age: _____

School: _____ Grade: _____

Hobbies & Interests: _____

_____

Your Home Phone: (___)_____ SS#: _____

Your Home Address: _____

_____
City State Zip

Whom may we thank for referring you? _____

Other family members seen in our practice: _____

_____

_____

Previous Dentist: _____

Last Visit: _____

Who is responsible for making appointments?

_____

Home Phone: (___)_____ Cell Phone: (___)_____

Work: (___)_____ Ext: ____ May we call you at work? _____

Email: _____

Who is accompanying you today?

Name: _____ Relation: _____

Does this person have legal custody of you? Yes ___ No___

Parent's Marital Status: Single ___ Married ___ Divorced ___
Separated ___ Widowed ___ Partnered ___

Mother's Information: Step Mother ___ Guardian ___

Name: _____ Birthdate: ____/____/____

Work #: (___)_____ Ext: ____ Home #: (___)_____

Employer: _____ Job Title: _____

SS#: _____ Driver's License #: _____

Father's Information: Step Father ___ Guardian ___

Name: _____ Birthdate: ____/____/____

Work #: (___)_____ Ext: ____ Home #: (___)_____

Employer: _____ Job Title: _____

SS#: _____ Driver's License #: _____

Person Responsible for Account:

Name: _____ Relation: _____

Billing Address: _____

_____
City State Zip

Work #: (___)_____ Ext: ____ Home #: (___)_____

Employer: _____ Cell #: (___)_____

SS#: _____ Driver's License #: _____

Primary Insurance Dental Coverage: Y__ N__ Medical Coverage: Y__ N__ Orthodontic Coverage: Y__ N__

Insurance Co. Name: _____ Phone: (___)_____ Group # (Plan or Policy #): _____

Insurance Co. Address: _____
Street / PO Box City State Zip

Insured's Name: _____ Insured's Soc. Sec #_____ Birthdate: ___/ ___/ ___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street / PO Box City State Zip

Secondary Insurance Dental Coverage: Y__ N__ Medical Coverage: Y__ N__ Orthodontic Coverage: Y__ N__

Insurance Co. Name: _____ Phone: (___)_____ Group # (Plan or Policy #): _____

Insurance Co. Address: _____
Street / PO Box City State Zip

Insured's Name: _____ Insured's Soc. Sec #_____ Birthdate: ___/ ___/ ___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street / PO Box City State Zip

Authorization of benefits: I certify that I am covered by the insurance noted above and I assign directly to Dr. George Mighion all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature: _____ Date: _____

YOUR HEALTH

Dental Health

Why have you come to the dentist today? _____

_____

Has you experienced any problems associated with previous dental work? Yes ___ No ___

Is your water fluoridated? Yes ___ No ___

Are you taking fluoride supplements? Yes ___ No ___

Have you ever had any pain or tenderness in your jaw joint (TMD/TMJ)? Yes ___ No ___

Do you brush daily? Yes ___ No ___

Do you floss daily? Yes ___ No ___

Do your gums bleed? Yes ___ No ___

Do you require antibiotics before dental work? Yes ___ No ___

Have you been evaluated for orthodontic treatment before? Yes ___ No ___

Have there been any injuries to your face, mouth, teeth, or chin? Yes ___ No ___

Have adenoids or tonsils been removed? Yes ___ No ___

Have you been informed of any missing or extra permanent teeth? Yes ___ No ___

Do you still have your wisdom teeth? Yes ___ No ___

Do you snore? Yes ___ No ___

Do you have a restless sleep? Yes ___ No ___

Medical Health

Your Physician: _____

Phone #: (___)_____ Date of Last Visit: _____

Your current physical health is: Good ___ Fair ___ Poor___

Are you now under the care of a physician? Yes ___ No ___

If yes, briefly explain why? _____

_____

_____

_____

Are your immunizations current? Yes ___ No ___

Please list all drugs you are currently taking: _____

_____

_____

_____

Have you ever had any of the following medical problems: (Please X all that apply)

___ Abnormal Bleeding
___ Anemia
___ Any Operations
___ Asthma
___ Chicken Pox
___ Convulsions / Epilepsy
___ Exposed to HIV, but Neg.
___ Hearing Impairment
___ Hepatitis
___ HIV+ / AIDS
___ Liver Problems
___ Measles
___ Mitral Valve Prolapse
___ Sickle Cell Disease / Traits
___ Tuberculosis (TB)
___ ADD / ADHD
___ Any Hospital Stays
___ Artificial Bones
___ Cancer
___ Congenital Heart Defect
___ Developmental Disabilities
___ Diabetes
___ Hemophilia
___ Hives
___ Kidney Problems
___ Lupus
___ Mononucleosis
___ Physical Disabilities
___ Rheumatic / Scarlet Fever
___ Skin Rash

Please briefly discuss any serious medical problems you have experienced: _____

_____

_____

Is there anything you would like to discuss with the doctor in private? Yes ___ No ___

Are you allergic to any of the following:

___ Aspirin
___ Plastic
___ Dental Anesthetics
___ Latex
___ Tetracycline
___ Metal / Jewelry
___ Codeine
___ Erythromycin
___ Penicillin
___ Other

Please list any other allergies you have: _____

_____

Did / do you experience any of the following:

___ Nursing Bottle Habits
___ Thumb / Finger Sucking
___ Clenching / Grinding Teeth
___ Mouth Breather
___ Breastfed
___ Speech Problems
___ Tongue Thrust
___ Lip Sucking / Biting
___ Nail Biting
___ Used a Pacifier

I understand that the parent or guardian that accompanies the child is responsible for payment at the time of service unless other arrangements have been previously approved.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of parent or guardian: _____ Date: _____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.