Today's Date: ______________________ Email Address: _____________________________________

Name: ____ I prefer to be called: ____________________________ _ Male _ Female
Last First Mi Mr Mrs Ms Dr

Birthdate: ___/___/___ Age: ______ Social Security #: ____________________ _ Single _ Married _ Divorced _ Widowed _ Child

Home Address: ____
Street City State Zip

Home Phone #: (___)_______________ Pager/Cell #: (____)________________ Work #: (___)____________ Driver Lic. #: ______________

Ballard Family Dentistry uses e-mail as a form of appointment confirmation. May we do so? **YES** **NO**

Where and when are the best times to reach you? ____________________ **Whom may we thank for referring you?** ________________________

Employer: ____________________________________ How long there? ____________ Occupation: _______________________________

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

Person Responsible for Account if other than yourself

Name: ______________________ Relation: _____________ Home Phone #: (_____)_____________ Social Security #: _________________

Employer: _________________________ Work Phone #: (_____)_______________ Ext: ______ Drivers License #: ____________________

Billing Address: ____
Street City State Zip

SPOUSE INFORMATION

His / Her Name: _____________________________________ Birthdate: ____/_____/______ Social Security #: _______________________

Employer: _____________________________ Work Phone #: (_____)______________ Ext: _____ Drivers License #: _________________

INSURANCE INFORMATION

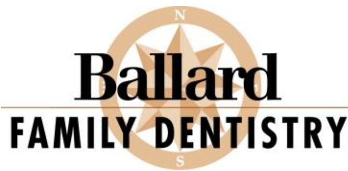
Primary Insurance Medical Coverage? _ Yes _ No Dental Coverage? _ Yes _ No Orthodontic Coverage? _ Yes _ No

Insurance Co. Name: _______________________ Phone #: (_______)____________ Group # (Plan, Local, or Policy #): __________________

Insurance Co. Address: ____
Street City State Zip

Insured's Name: _________________ Insured's Social Security #: ____________ Insured's Birthdate: ___/___/____ Relation: _____________

Insured's Employer: ______________ Employers Address: ____
Street / PO Box City State Zip



MEDICAL HISTORY

Do you have a personal physician? _ Yes _ No

Physician's Name: ______________________________________

Address: ____
Street

____
City State Zip Code

Your current physical health is: _ Good _ Fair _ Poor

Are you currently under the care of a physician? _ Yes _ No

Please explain: ______________________________________

Do you smoke or use tobacco in any other form? _ Yes _ No

How much do you smoke or use per day? ______________________

Are you allergic to any of the following?

	Item		Item		Item
Y N	Aspirin	Y N	Erythromycin	Y N	Sedatives
Y N	Barbiturates	Y N	Jewelry / Metals	Y N	Sulfa Drugs
Y N	Codeine	Y N	Latex	Y N	Tetracycline
Y N	Penicillin	Y N	Dental Anesthetics	Y N	Other

Please list additional drugs / materials that cause allergic reactions:

____

____

For Women: Are you taking birth control pills? _ Yes _ No

Are you pregnant? _ Unsure _ Yes _ No

Week #: ___________ Are you nursing? _ Yes _ No

Have you ever or are you taking any of the following?

	Item		Item		Item		Item
Y N	Acetaminophen	Y N	Blood Thinners	Y N	Insulin / Diabetes Drugs	Y N	Steroids / Cortisone
Y N	Alendronate (fosamax)	Y N	Blood Pressure Medication	Y N	Ibandronate (Boniva)	Y N	Tiludronate (Skelid)
Y N	Antibiotics	Y N	Cold Remedies	Y N	Nitroglycerin	Y N	Thyroid Medicine
Y N	Antihistamines	Y N	Digitalis/ Heart Medication	Y N	Pamidronate (Aredia)	Y N	Tranquilizers
Y N	Aspirin	Y N	Etidroname Disodium (Vidronel)	Y N	Recreational Drugs	Y N	Zoledronic Acid (Zometa)
Y N	Bisphosphonate			Y N	Risedronate (Actonel)		

Are you taking any prescription / over-the-counter-drugs not listed above? _ Yes _ No

Please list any medications you are currently taking: ______________________________

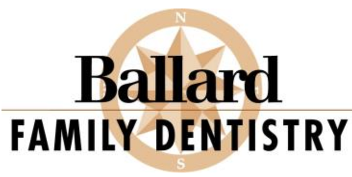
____

Do you or have you experienced the following?

	Item		Item		Item		Item		Item
Y N	Abnormal Bleeding	Y N	Colitis	Y N	Heart Attack	Y N	Liver Disease	Y N	Sickle Cell Disease
Y N	Alcohol Abuse	Y N	Congenital Heart Defect	Y N	Heart Murmur	Y N	Lupus	Y N	Sinus Problems
Y N	Anemia	Y N	Diabetes	Y N	Heart Surgery	Y N	Mitral valve Prolapse	Y N	Steroid Therapy
Y N	Arthritis	Y N	Difficulty Breathing	Y N	Hemophilia	Y N	Pacemaker	Y N	Stroke
Y N	Artificial Bones/ Joints	Y N	Drug Abuse	Y N	Hepatitis	Y N	Persistent Cough	Y N	Thyroid Problems
		Y N	Emphysema	Y N	Herpes	Y N	Psychiatric Problems	Y N	Tonsillitis
Y N	Asthma	Y N	Epilepsy	Y N	High Blood Pressure	Y N	Radiation Treatment	Y N	Tuberculosis (TB)
Y N	Blood Transfusion	Y N	Fainting Spells	Y N	HIV+ / AIDS	Y N	Rheumatic Fever	Y N	Ulcers
Y N	Cancer	Y N	Glaucoma	Y N	Kidney Problems	Y N	Scarlet Fever	Y N	STD/ Venereal Disease
Y N	Chemotherapy	Y N	Hay Fever	Y N	Hospitalized for Any Reason	Y N	Seizures		
Y N	Chicken Pox	Y N	Headaches			Y N	Shingles		

Other (please list): ______________________________________

____



DENTAL HISTORY

Why have you come to the dentist today? ______________________

____

Are you currently in pain? _ Yes _ No

Please rate your pain on a scale of 1-10 with 1 being little pain and 10 being unbearable pain. _______

Previous / Present Dentist: ___________________________________

City ______________________________ State ___________________

Phone Number ____

When was your last: cleaning? ________ oral cancer test? _______

Why did you leave your previous dentist? _______________________

____

What did you like most & least about any dentist you have seen? ____

____

____

Do you require antibiotics before dental treatment _ Yes _ No

Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ / TMD)? _ Yes _ No

Do you have headaches, ear aches, neck or jaw pain? _ Yes _ No

Do you floss daily? _ Yes _ No Brush daily? _ Yes _ No

Do you use anything in addition to floss? _ Yes _ No

If yes, what? ____

Do you or have you ever suffered from extreme dry mouth? _ Yes _ No

Do you still have wisdom teeth? _ Yes _ No

Do your gums ever bleed, get swollen or irritated? _ Yes _ No

Have you ever had periodontal disease? _ Yes _ No

Do you have loose, shifting or tipped teeth? _ Yes _ No

Do you have any teeth or fillings broken? _ Yes _ No

Are your teeth sensitive to heat, cold, or anything else? _ Yes _ No

Do you have mouth ulcers or cold sores? _ Yes _ No

Do you have bad breath? _ Yes _ No

Do you have or have you had any of the following?

Dentures or Partials _ Yes _ No

Braces _ Yes _ No

Gum Treatment Yes No

Are you happy with the way your smile looks?_________________

Please rate your smile on a scale of 1-10 with 10 being the best ____

If I could change my smile, I would:

Whiten my teeth? _ Yes _ No

Make my teeth straighter? _ Yes _ No

Close spaces between teeth? _ Yes _ No

Replace metal fillings with tooth colored ones? _ Yes _ No

Repair chipped teeth? _ Yes _ No

Replace missing tooth? _ Yes _ No

Replace old crowns that don't match? _ Yes _ No

Have a smile make over? _ Yes _ No

On a scale of 1-10, with 10 being the highest rating:

How important is dental health to you?
1 2 3 4 5 6 7 8 9 10

How would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Ballard Family Dentistry
Courtesy Billing
Our office requires at least 72 hour notice prior to an appointment Cancellation or Change.

As a courtesy to you, we will verify your insurance benefits, file all of your dental claims, inform you when your insurance company has neglected to pay the estimated amount and we will file an appeal on your behalf when necessary.

You will be responsible for paying your co-payments and deductibles at the time of service, paying any remaining balance after insurance payments are received, providing us with the most current insurance information, and being aware of your dental benefits and coverage.

I have read and understand the conditions of the Courtesy Billing Options above. I certify that I am covered by _____________________ Insurance Co. and I assign directly to Ballard Family Dentistry all insurance benefits. I understand that I am responsible for payment of services rendered, and also responsible for paying any co-payments and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

______________________________ ______________________________ ____________
Print Name Signature Date