Midtown Dental Group

Patient Name: ____
Last Name First Name (Preferred)

Male ☐ Female ☐ ☐ Married ☐ Single ☐ Child

Address: ____
Street Apartment #

____
City State Zip Code

Date of Birth: ________________________ Social Security ____________________

Phone (Mobile) :_____________________(Work):_____________________ Ext:____

Email Address: ____

Emergency Contact: Name: ______________________ Phone: __________________
Relationship________________

How did you hear about our practice?

____ZocDoc

____Yelp

____Google

____Patient Referral:

____

Date of Appointment: ____________

Name ____________ Gender ______ Age ______

Reason for Visit

What brings you to the office today?

Is there anything you would like to change about your smile?

Current Medications

Are you currently taking any blood thinners?

☐ Yes ☐ No

What medications are you currently taking?

Name	Dosage	Frequency

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name	Reaction

Hospitalizations & Surgeries

Reason	Date

Dental History

When was your last dental exam?

Date ____________

When were your last dental x-rays taken?

Date ____________

How often do you brush?

times/day ____________

How often do you floss?

times/day ____________

Do you grind your teeth?

☐ Yes ☐ No

Have you ever had orthodontic (braces) treatment?

☐ Yes ☐ No

Have you ever had periodontal (gum) treatments?

☐ Yes ☐ No

Do you have any of the following?

☐ Bad Breath ☐ Dry Mouth ☐ Partials
☐ Bleeding Gums ☐ Difficulty Chewing ☐ Sensitivity to Cold
☐ Blisters on Mouth ☐ Ear Pain ☐ Sensitivity to Heat
☐ Broken Fillings ☐ Jaw Pain ☐ Sensitivity to Sweets
☐ Clicking Jaw ☐ Loose Teeth ☐ Sensitivity to Pressure
☐ Dentures ☐ Mouth Pain ☐ Swollen Gums
☐ Difficulty Opening or Closing ☐ Mouth Sores

Past Medical History

Have you ever had any of the following?

☐ Alcoholism ☐ Bleeding Disorder ☐ Eating Disorder
☐ Allergies ☐ Blood Disease ☐ Epilepsy
☐ Anemia ☐ Blood Transfusion ☐ Hay Fever
☐ Anxiety Disorder ☐ Bowel Disorder ☐ Heart Disease Heart
☐ Arthritis ☐ Cancer ☐ Problems Hepatitis -
☐ Asthma ☐ Diabetes ☐ A, B, or C High
☐ AIDS / HIV ☐ Depression ☐ Blood Pressure

☐ High Cholesterol ☐ Migraines ☐ Stomach Ulcer
☐ Joint Disorder ☐ Osteoporosis ☐ Substance Abuse
☐ Kidney Disorder ☐ Pacemaker ☐ Thyroid Disorder
☐ Liver Disorder ☐ Rheumatic Fever ☐ Tuberculosis
☐ Lung Disease ☐ Sinus Problems ☐ Venereal Disease
☐ Lupus ☐ Skin Disorder
☐ Measles ☐ Stroke

Lifestyle Factors

Have you ever smoked?

☐ Yes ☐ No # of years ____________ # packs/day ____________

Do you smoke now?

☐ Yes ☐ No # packs/day ____________

Do you use recreational drugs?

☐ Yes ☐ No types? ____________ # times/week ____________

How much alcohol do you drink per week?

drinks/week ____________

How much caffeine do you drink per day?

drinks/day ____________

Women Only

Are you pregnant?

☐ Yes ☐ No

Are you breastfeeding?

☐ Yes ☐ No

What is your method of birth control?

Financial Agreement

This agreement is to inform you of your financial obligation to our practice. Please understand that payment of your bill is considered a part of your treatment. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health.

All charges you incur are your responsibility regardless of any insurance coverage or benefit plan that may assist you in completing your dental treatment. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. As a courtesy to you we will complete your insurance claims and submit to your insurance for payment. In order for our practice to seek reimbursement from your insurance company, we ask that you please provide us with all insurance information needed.

Insurance Information:

Insurance Company:________________________

Member ID:__________________________

Group Number:___________________

Primary Insured:_________________

Insured Birth date:________________

Payment for treatment is due prior to or the same day the treatment is provided. Our practice accepts cash, personal checks, MasterCard and Visa. Third party, extended payment financing is also available upon request and approval. Returned checks and past due balances will be subject to collection fees and finance charges. If you would like to keep your credit card information securely on file, we will be happy to help you.

Additionally, our practice will charge you for appointments that you do not keep and for appointments that you do not cancel with 48-hours notice.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care.

Patient Signature:_____________________________

Date:________________

Midtown Dental Group
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