ABOUT YOU

Today's Date:_____/_____/_____

Patient Name:_____
LAST FIRST MI

Preferred Name:_____ ( ) Male ( ) Female

D.O.B:____/____/____ Age:_____ SS#_____-____-_____

Mailing Address:_____

_____
CITY STATE ZIP

Preferred

( ) Home Phone #:(_____) _____

( ) Cell Phone #:(_____) _____

( ) Work Phone #:(_____) _____

E-mail Address:_____

Referred by:_____

Employer:_____

Employer's Address:_____

_____
CITY STATE ZIP

Occupation:_____

Status: ( ) Single ( ) Married ( ) Partnership ( ) Widowed

Spouse/Partner's Name:_____

ACCOUNT INFO

Person ultimately responsible for account ( ) SELF

Name:_____
LAST FIRST MI

Relation:_____

Billing Address: ( ) Same as above

_____

_____
CITY STATE ZIP

SS#_____-___-_____ Driver's License #_____

Cell Phone #:(_____) _____

Work Phone #:(_____) _____

Payment Method: ( )Cash ( )Check ( )Credit Card

_____ I hereby authorize assignment of my insurance rights and benefits to Arlington Dental Solutions, office of Dr. Tamara Garrett. I fully understand I am solely responsible for any balance not paid by my insurance company.

WELCOME TO OUR OFFICE. PLEASE TAKE A FEW MOMENTS TO COMPLETE THIS FORM SO THAT WE MAY PROVIDE YOU WITH STATE OF THE ART CARE.

INSURANCE INFO

DO YOU HAVE DENTAL INSURANCE? ( ) YES ( ) NO

PRIMARY INSURANCE

Ins. Co. Name:_____

Address:_____

_____
CITY STATE ZIP

Phone #:(_____) _____

Insured's Name:_____

Relation:_____ DOB: _____/_____/_____

Insured's Employer:_____

Insured's ID#_____

Group # (Plan ID, Local #, Policy#)_____

SECONDARY INSURANCE

Ins. Co Name:_____

Address:_____

_____
CITY STATE ZIP

Phone #:(_____) _____

Insured's Name:_____

Relation:_____ DOB: _____/_____/_____

Insured's Employer:_____

Insured's ID#_____

IN EVENT OF EMERGENCY

Whom should we contact:_____

Relation:_____

Home Phone #:(_____) _____

Cell Phone #:(_____) _____

Work Phone #:(_____) _____

DENTAL INFORMATION

Reason for today's visit: ( ) Exam/Consultation ( ) Emergency Are you in pain: ( ) No ( ) Yes How long:_____

Please indicate any of the following problems you may have:

( ) Clicking, pain, or popping in jaw ( ) Sensitive teeth ( ) Red, swollen, or bleeding gums ( ) Lost or broken fillings
( ) Ringing in ears ( ) Frequent headaches ( ) Teeth Grinding ( ) Blisters/sores in or around mouth
( ) Bad Breath ( ) Broken or chipped teeth ( ) Stained Teeth ( ) Unhappy with appearance of teeth or smile

Previous dentist name:_____ Phone # (_____) _____

MEDICAL HISTORY

Physician Name:_____ Phone # (_____) _____

Do you require antibiotic pre-medication? ( ) Yes ( ) No ( ) I don't know

Do you require a change in your medication before dental treatment? (ie:blood thinners, diuretics) ( ) Yes ( ) No

Are you CURRENTLY taking any of the following medications?

( ) Nerve Pills ( ) Pain medication ( ) Blood Thinners ( ) Aspirin ( ) Muscle Relaxers

( ) Stimulants ( ) Insulin ( ) Osteoporosis Meds ( ) Tranquilizers

( ) NONE or ( ) Other medication not listed

_____

_____

_____

Have you EVER taken the following: ( ) Biosphosphates ie: Aredia/Fosamax ( ) Phen-fen/Redux

Do you have or have you ever had any of the following:

( ) Heart Attack	( ) Kidney Problems	( ) HIV/AIDS/ARC	( ) X-ray Treatment	( ) Glaucoma
( ) Stroke	( ) Liver Problems	( ) Arthritis	( ) Chemotherapy	( ) Hepatitis_____
( ) Heart Murmur	( ) Sinus Problems	( ) Psychiatric Problems	( ) Asthma	( ) Nervousness
( ) MVP	( ) Sinus Problems	( ) Rheumatism	( ) Difficulty Breathing	( ) Anemia
( ) Rheumatic Fever	( ) Venereal Disease	( ) Artificial Bones	( ) Diabetes	( ) Fainting
( ) Artificial Valves	( ) Artificial Joints	( ) Alcohol Abuse	( ) Hypoglycemia	( ) Shingles
( ) Heart Disease	( ) Drug Abuse	( ) Emphysema	( ) Leukemia	( ) Neck Pain
( ) Heart Defect	( ) Tuberculosis	( ) Chest Pains	( ) Jaw Problems/TMJ	( ) Frequent Headaches
( ) High Blood Pressure	( ) Low Blood Pressure	( ) Scarlet Fever	( ) Cancer/Tumors	( ) Back Problems
( ) Bleeding Problems	( ) Thyroid Problems	( ) Cosmetic Surgery		

Are you allergic to any of the following? ( ) Latex ( ) Penicillin/Amoxicillin ( ) Tetracycline ( ) Aspirin ( ) Dental Anesthetic
( ) Sulfa ( ) Foods:_____ ( ) Other:_____

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

Rate your general health from 1-10:_____

FOR WOMEN ONLY: Are you taking birth control pills? ( ) Yes ( ) No
Are you pregnant? ( ) No ( ) Yes/How long?_____ Are you nursing? ( ) No ( ) Yes

I understand the above information and guarantee this firm 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:_____/_____/_____