Patient Information

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as thoroughly as you can.
If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date ____________ Phone ( ) __________________ Cell ( ) __________________

Name ____ ID#/Soc Sec # __________________
Last Name First Name Middle Initial

Address ____________________________ City ______________ State _____ Zip ____________

Sex ☐ M ☐ F Age _____ Birthdate ____________

Please provide your E-Mail address if you wish to receive information from us about future promotions, newsletters, education materials, etc.:

Patient's E-mail Address ______________________________

Married ☐ Widowed ☐ Single ☐ Separated ☐ Divorced ☐ Partnered for ____ years Minor ☐

Patient Employer/School ______________________________ Occupation ______________________________

Employer/School Address ______________________________ Employer/School Phone ( ) ______________

In case of emergency, who should be notified ? ______________________________ Phone ( ) ______________

Please provide the name of any person or persons you wish to grant permission to TruCare Dental the ability to discuss personal, insurance, financial or dental treatment plan information with (i.e., spouse, parent, guardian, other relative, etc.)

____

Whom may we thank for referring you? ______________________________

PRIMARY DENTAL INSURANCE

Person Responsible for Account: ____
Last Name First Name Middle Initial

Relation to Patient ______________ Birthdate ______________ ID#/Soc Sec # ______________

Address (If different from Patient's) ______________________________ Phone ( ) ______________

City ______________ State _____ Zip ______________

Person Responsible Employed By ______________ Occupation ______________

Business Address ______________________________ Business Phone ( ) ______________

Insurance Company ______________________________ Contract # ______________

Contract # ______________ Group # ______________ Subscriber # ______________

INSURANCE AUTHORIZATION

I certify that I, and/or my dependent(s), have insurance coverage with ______________________________ and assign directly to TruCare Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize use of my signature on all insurance submissions. TruCare Dental may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____ ______________

Signature of Patient, Parent, Guardian or Personal Representative Date

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED

ADDITIONAL INSURANCE (MEDICAL OR DENTAL)

Person Responsible for Account: ____
Last Name First Name Middle Initial

Relation to Patient ______________ Birthdate ______________ ID#/Soc Sec # ______________

Address (If different from Patient's) ______________________________ Phone ( ) ______________

City ______________ State ______________ Zip ______________

Person Responsible Employed By ______________ Occupation ______________

Business Address ______________________________ Business Phone ( ) ______________

Insurance Company ______________________________ Contract #______________

Contract # ______________ Group # ______________ Subscriber # ______________

Please complete other side

DENTAL HISTORY

Reason for Today's Visit ______________________ Date of last dental care ______________

Former Dentist ______________________ Date of last dental x-rays ______________

Address ____

Check (√) If you have had problems with any of the following:

☐ Bad Breath ☐ Bleeding gums ☐ Clicking or popping jaw ☐ Food collection between teeth ☐ Grinding teeth

☐ Loose teeth or broken fillings ☐ Periodontal treatment ☐ Sensitivity to cold ☐ Sensitivity to hot

☐ Sensitivity to sweets ☐ Sensitivity when biting ☐ Sores or growths in your mouth

How often do you floss? ______________ How often do you brush? ______________

MEDICAL HISTORY

Physician's Name ______________________ Date of Last Visit ______________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These includes combinations of Lonimin, Adipex, Fastin (brand names of phentermine). Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Do you currently (or have you in the past) taken any Bisphosphonates (e.g. Boniva, Fosamax, Actonel)? ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe ______________

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates ______________

(Women) Are you pregnant? ☐ Yes ☐ [illegible] ☐ Yes ☐ [illegible] ☐ Yes ☐ No

Check (√) If you have had problems with any of the following:

☐ Anemia	☐ Cortisone Treatments	☐ Hepatitis	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cough, Persistent	☐ High Blood Pressure	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Cough up Blood	☐ HIV/AIDS	☐ Skin Rash
☐ Artificial Joints	☐ Diabetes	☐ Jaw Pain	☐ Stroke
☐ Asthma	☐ Epilepsy	☐ Kidney Disease	☐ Swelling of Feet or Ankles
☐ Back Problems	☐ Fainting	☐ Liver Disease	☐ Thyroid Problems
☐ Blood Disease	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tobacco Habit
☐ Cancer	☐ Headaches	☐ Pacemaker	☐ Tonsillitis
☐ Chemical Dependency	☐ Heart Murmur	☐ Radiation Treatment	☐ Tuberculosis
☐ Chemotherapy	☐ Heart Problems	☐ Respiratory Disease	☐ Ulcer
☐ Circulatory Problems	☐ Hemophilia	☐ Rheumatic Fever	☐ Venereal Disease

MEDICATIONS

List Medications you are currently taking below:

____

____

____

____

☐ ALLERGIES

List Allergies you have below:

____

____

____

____

MEDICAL HISTORY FORM AUTHORIZATION

Please provide your signature below to indicate you have completed this medical history form to the best of your knowledge and ability and have provided to TRUCARE DENTAL accurate and thorough information regarding your medical history and contact information. We are required to ask you to update this form once every 12 months:

______________________________ ______________

Signature of Patient, Parent, Guardian or Personal Representative Date