Date_____

Patient Information

Name_____SSN_____
Last Name First Name MI

Address_____E-mail_____
City_____State_____Zip_____

Sex ☐ M ☐ F Birthdate_____ ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered

Phone # Cell_____Home_____Work_____

Employer/School_____ Occupation_____
Employer address_____
Whom may we thank for referring you?_____

Insurance

Primary

Person Responsible for Account_____
Last Name First Name MI

Relation to Patient_____DOB_____SSN_____
Address (if different from patient's)_____
City_____State_____Zip_____Phone_____
Employer_____Occupation_____
Business Address_____Business Phone_____
Insurance Company_____
Contract #_____Group #_____Subscriber #_____

Additional

Subscriber Name_____Relation_____DOB_____
Address (if different from patient's)_____
City_____State_____Zip_____Phone_____
Employer_____Occupation_____
Insurance Company_____SSN_____
Contract #_____Group #_____Subscriber #_____

Dental History

Reason for Today's Visit_____Date of last exam_____
Former Dentist_____Date of last dental x-rays_____

Indicate if you have or have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking/popping jaw
- ☐ Food trap between teeth
- ☐ Grinding teeth
- ☐ Loose teeth/broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores/growths in mouth

How often do you brush?_____How often do you floss?_____

Medical History

Physician's Name_____Date of last visit_____

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

_____

(Women)Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Birth Control Pills? ☐ Yes ☐ No

Indicate if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Cortisone Treatments
- ☐ Cough, persistent
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ HIgh blood pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Chemotherapy
- ☐ Circulatory Problem
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tuberculosis
- ☐ Venereal Disease

Medications:

_____

_____

Allergies:

_____

_____

Authorization:

I certify that I, and/or my dependent(s), have insurance coverage with_____

And assign directly to the doctors of McCandless Dental Care, PLLC 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 the use of my signature on all insurance submissions.

McCandless Dental Care, PLLC 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.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative | Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative | Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been made.