

Welcome to the Amlin Dental Team

Dependent Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family E-Mail: _____

Social Security #: _____ Birth Date: _____

Phone Home: _____ Cell: _____ E-mail: _____

Do you prefer to be contacted by: phone, e-mail or text message

Address: _____
Street Apartment #

City State Zip Code

Father's Information

Father's Name: _____
Last, First MI (Preferred Name)

Social Security #: _____ Birth Date: _____

Phone Home: _____ Work: _____ Cell: _____

Address (if different from child's): _____
Street Apartment #

City State Zip

Father's Employer Information

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Mother's Information

Mother's Name: _____
Last, First MI (Preferred Name)

Social Security #: _____ Birth Date: _____

Phone Home: _____ Work: _____ Cell: _____

Address (if different from child's): _____
Street Apartment #

City State Zip

Mother's Employer Information

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Dental Insurance Information

Primary Insurance - insured is Mother Father Other _____

Primary

ID #: _____ Group #: _____

Insurance Plan Name and Address: _____

Secondary

ID #: _____ Group #: _____

Insurance Plan Name and Address: _____

Referral Information

Whom may we thank for referring you to our practice? friend relative Dental Office Yellow Pages

Name of person or office referring you to our practice: _____

Health History

PLEASE CIRCLE ANY OF THE FOLLOWING THAT YOU HAVE HAD OR HAVE AT THE PRESENT

ACID STOMACH	DIABETES	HEPATITIS B (SERUM)	PSYCHIATRIC TREATMENT
AIDS	DRUG / ALCOHOL ADDICTION	HIGH BLOOD PRESSURE	RHEUMATIC FEVER
ANGINA PECTORIS	EMPHYSEMA	HIV POSITIVE	RHEUMATISM
ARTHRITIS	EPILEPSY OR SEIZURES	JAUNDICE	SCARLET FEVER
ARTIFICIAL HEART VALVE	GLAUCOMA	KIDNEY TROUBLE	SEXUALLY TRANSMITTED DISEASES
ARTIFICIAL JOINT	HAY FEVER	LOW BLOOD PRESSURE	SICKLE CELL DISEASES
ASTHMA	HEART DISEASE OR ATTACK	MYTRAL VALVE PROLAPSE	SINUS TROUBLE
BRUISE EASILY	HEART FAILURE	NERVOUSNESS	STROKE
CHEMOTHERAPY	HEART MURMUR	ORGAN TRANSPLANT	THYROID DISEASE
CHRONIC COUGH	HEART PACEMAKER	ORTHODONTIC (BRACES) TREATMENT	TUBERCULOSIS (TB)
COLD SORES	HEART SURGERY	PAIN IN JAW (TMJ)	ULCERS
CORTISONE MEDICATION	HEPATITIS A (INFECTION)	PERIODONTAL (GUM) SURGERY	X-RAY OR COBALT TREATMENT

COMMENTS: _____

ALLERGIES: _____

LIST ANY MEDICATIONS YOU ARE USING: _____

• Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

• Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: _____

• Are you now under the care of a physician? Yes No

If yes, please explain: _____

• Name of Physician: _____ Phone: _____

• Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

DENTAL HISTORY

LAST DENTAL VISIT: _____ X-RAYS: _____
DATE DATE

Are you apprehensive (nervous) about your dental treatment? Yes No

Have you had nitrous Oxide Medication Prior To Treatment

WHAT WOULD YOU LIKE US TO DO FOR YOU?

- | | | |
|--|---|--|
| <input type="checkbox"/> HELP ME KEEP MY TEETH FOR THE REST OF MY LIFE | <input type="checkbox"/> HELP ME IMPROVE MY SMILE | <input type="checkbox"/> CHECK MY MOUTH AND GIVE ME A REPORT |
| <input type="checkbox"/> I WANT TO PREVENT DECAY AND TOOTHACHES | <input type="checkbox"/> I WANT FRESHER BREATH | <input type="checkbox"/> I WANT STRAIGHT TEETH |
| <input type="checkbox"/> I WANT WHITER TEETH | <input type="checkbox"/> STOP MY GUMS FROM BLEEDING | <input type="checkbox"/> TEACH ME HOW TO CARE FOR MY TEETH |
| <input type="checkbox"/> GET ME OUT OF PAIN | <input type="checkbox"/> FIX THE HOLE IN MY TOOTH | <input type="checkbox"/> REPLACE MY MISSING TEETH |
| <input type="checkbox"/> REMOVE MY WISDOM TOOTH | | |

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____