# Canton Dental Clinic

## Patient Information

Date _____

Patient Name_____ Age _____ Sex: M ☐ F ☐
Last First Middle

Mailing Address _____ How long ?____**Email :**_____
Street City State Zip

**Home Phone** (____)_____**Cell Phone** (___) _____ Birthdate _____Social Security #_____

Employer _____ Occupation _____ **Work Phone** (___) _____ School _____

Spouse's Name _____ Birthdate _____ Social Security # _____

Employer _____ Occupation _____ **Work Phone** (___) _____

How did you hear about Canton Dental Clinic?_____

## Responsible Party Information ( If parent is responsible for account)

**Father's Name** _____ Birthdate _____ Social Security # _____

Address _____ Home Phone (___) _____

Employer _____ Occupation _____ Work Phone (___) _____

**Mother's Name** _____ Birthdate _____ Social Security # _____

Address _____ Home Phone (___) _____

Employer _____ Occupation _____ Work Phone (___) _____

## Do you have Dental Insurance? Yes No

**Primary Insurance Company**:

Subscriber's Name _____

Subscriber's Address _____

Subscriber's Soc. Sec. # _____

Insurance Company _____

Group No. _____ ID No. _____

Insurance Co. Address _____

Telephone (_____)_____

Subscriber's Employer/Address_____

_____

Do you have dual coverage? Yes ☐ No ☐ If yes:

Subscriber's Name _____

Subscriber's Soc. Sec. # _____

Insurance Company_____

Group No. _____ ID No. _____

Ins. Co. Address_____

Telephone (_____)_____

Subscriber's Employer/Address _____

_____

Is patient covered under Medicaid? # _____

## Authorization and Release

I have read and answered all questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions. I understand that where appropriate, credit bureau reports may be obtained.

**Signature of patient (or parent if minor )_____(required)** Date _____

Prefered Method of Payment: cash ☐ check ☐ credit card ☐

**Payment is due in full at time of treatment unless prior arrangements have been approved. 5% cash discount**

**(over please)**

## Please complete if you are a "new" patient

**Patient Name**

_____

Reason for today's visit_____

_____

Former Dentist _____

City/State _____

Date of last dental visit_____

For what service_____

Date of last dental X-rays _____

Place a mark "Yes" or "No" to indicate if you have had any of the following:

| | | |
|---|---|---|
| Bad breath | ☐ Yes | ☐ No |
| Bleeding gums | ☐ Yes | ☐ No |
| Blisters on lips or mouth | ☐ Yes | ☐ No |
| Burning sensation on tongue | ☐ Yes | ☐ No |
| Smoking/tobacco habit | ☐ Yes | ☐ No |
| Clicking or popping jaw | ☐ Yes | ☐ No |
| Dry mouth | ☐ Yes | ☐ No |
| Fingernail biting | ☐ Yes | ☐ No |
| Food collection between the teeth | ☐ Yes | ☐ No |
| Grinding teeth | ☐ Yes | ☐ No |
| Gums swollen or tender | ☐ Yes | ☐ No |
| Jaw pain or tiredness | ☐ Yes | ☐ No |
| Lip or cheek biting | ☐ Yes | ☐ No |
| Loose teeth or broken fillings | ☐ Yes | ☐ No |
| Mouth pain, brushing | ☐ Yes | ☐ No |
| Pain around ear | ☐ Yes | ☐ No |
| Periodontal treatment | ☐ Yes | ☐ No |
| Sensitivity to cold | ☐ Yes | ☐ No |
| Sensitivity to heat | ☐ Yes | ☐ No |
| Sensitivity to sweets | ☐ Yes | ☐ No |
| Sensitivity when biting | ☐ Yes | ☐ No |
| Sores or growths in your mouth | ☐ Yes | ☐ No |

How often do you floss? _____

How often do you brush? _____

Do you drink purified water? _____

## Medical History

Physician's Name _____ Date of last visit _____

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 _____

Have you ever been told you cannot give blood? _____ Reason

_____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

| | | |
|---|---|---|
| AIDS | ☐ Yes | ☐ No |
| Abnormal bleeding from a cut | ☐ Yes | ☐ No |
| Anemia | ☐ Yes | ☐ No |
| Arthritis, Rheumatism | ☐ Yes | ☐ No |
| Artificial Heart Valves | ☐ Yes | ☐ No |
| Artificial Joints | ☐ Yes | ☐ No |
| Asthma | ☐ Yes | ☐ No |
| Back Problems | ☐ Yes | ☐ No |
| Blood Disease | ☐ Yes | ☐ No |
| Cancer | ☐ Yes | ☐ No |
| Chemical Dependency | ☐ Yes | ☐ No |
| Chemotherapy | ☐ Yes | ☐ No |
| Circulatory Problems | ☐ Yes | ☐ No |
| Cortisone Treatments | ☐ Yes | ☐ No |
| Cough, Persistent | ☐ Yes | ☐ No |
| Cough up Blood | ☐ Yes | ☐ No |
| Diabetes | ☐ Yes | ☐ No |
| Emphysema | ☐ Yes | ☐ No |
| Epilepsy | ☐ Yes | ☐ No |
| Fainting | ☐ Yes | ☐ No |
| Glaucoma | ☐ Yes | ☐ No |
| Headaches | ☐ Yes | ☐ No |
| Heart Murmur | ☐ Yes | ☐ No |
| Heart Problems | ☐ Yes | ☐ No |
| Describe _____ | | |
| Hemophilia | ☐ Yes | ☐ No |
| Hepatitis -Type _____ | ☐ Yes | ☐ No |
| Herpes | ☐ Yes | ☐ No |
| High Blood Pressure | ☐ Yes | ☐ No |
| HIV Positive | ☐ Yes | ☐ No |
| Jaundice | ☐ Yes | ☐ No |
| Kidney Disease | ☐ Yes | ☐ No |
| Liver Disease | ☐ Yes | ☐ No |
| Mitral Valve Prolapse | ☐ Yes | ☐ No |
| Parkinson Disease | ☐ Yes | ☐ No |
| Pacemaker | ☐ Yes | ☐ No |
| Psychiatric Care | ☐ Yes | ☐ No |
| Radiation Treatment | ☐ Yes | ☐ No |
| Respiratory Disease | ☐ Yes | ☐ No |
| Rheumatic Fever | ☐ Yes | ☐ No |
| Scarlet Fever | ☐ Yes | ☐ No |
| Shortness of Breath | ☐ Yes | ☐ No |
| Sinus Trouble | ☐ Yes | ☐ No |
| Skin Rash | ☐ Yes | ☐ No |
| Stroke | ☐ Yes | ☐ No |
| Swollen Neck Glands | ☐ Yes | ☐ No |
| Swelling of Feet or Ankles | ☐ Yes | ☐ No |
| Thyroid Problems | ☐ Yes | ☐ No |
| Tobacco Habit | ☐ Yes | ☐ No |
| Tonsillitis | ☐ Yes | ☐ No |
| Tuberculosis/TB | ☐ Yes | ☐ No |
| Ulcer | ☐ Yes | ☐ No |
| Osteoporosis | ☐ Yes | ☐ No |
| Sleep Apnea | ☐ Yes | ☐ No |

## Medications

List medications you are currently taking:

_____

_____

_

Pharmacy Name_____Phone_____

## Allergies

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping Pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex _____

## Emergency Information

Name of nearest relative not living with you _____Phone

_____

**Future Updates:** Signature _____ Date _____ Signature _____ Date_____