Welcome to Enlightened Dentistry!

Thank you for selecting our dental healthcare team!

We will strive to provide you with the best possible dental care. To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name _____

SS# _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Email _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If Student, Name of School/College _____ City _____ State _____ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS# _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check ☐ Credit Card VISA / MasterCard / Discover ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Date Employed _____

Name of Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Ins. Co. Phone _____

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to biting, hot, cold or sweets?	☐	☐
3. Do you feel pain to any of your teeth?	☐	☐
4. Do you have any sores or lumps in or near your mouth?	☐	☐
5. Have you had any head, neck or jaw injuries?	☐	☐
6. Do you have any dental implants?	☐	☐
If yes, please explain _____		
7. Do you have frequent headaches?	☐	☐
8. Do you clench or grind your teeth?	☐	☐
9. Do you bite your lips or cheeks frequently?	☐	☐
10. Have you ever had any difficult extractions in the past?	☐	☐
11. Have you ever had any prolonged bleeding following extractions?	☐	☐
12. Have you had any orthodontic treatment?	☐	☐
13. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
14. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
15. Are you concerned about your breath?	☐	☐
16. Would you like to have fresher breath?	☐	☐
17. Do you like your smile?	☐	☐
18. Would you like to have whiter teeth?	☐	☐
19. What is your long term goal for your teeth and overall oral health? _____		

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain _____		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. Do you use tobacco?	☐	☐
5. Do you use controlled substances?	☐	☐
6. Are you wearing contact lenses?	☐	☐

8. Are you allergic to or have you had any reactions to the following:	Yes	No
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other _____	☐	☐
9. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
10. Women Only:		
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

7. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐	Other _____	☐	☐

PAYMENT IS EXPECTED AT THE TIME OF EACH VISIT. INTEREST WILL BE CHARGED AT THE RATE OF 1.5% PER MONTH (APR 18%) ON ALL ACCOUNTS DUE OVER THIRTY (30) DAYS. YOU WILL BE RESPONSIBLE FOR PAYMENT ON ALL LEGAL AND COLLECTION FEES INCURRED BY PAST DUE ACCOUNTS. IN THE EVENT OF ANY RETURNED CHECKS, A FIFTEEN DOLLAR ($15.00) SERVICE FEE PLUS ANY BANK CHARGES INCURRED WILL BE YOUR RESPONSIBILITY.

ALL BROKEN APPOINTMENTS (LESS THAN 48 HOURS NOTICE) WILL BE BILLED TO YOUR ACCOUNT FOR THE FULL FEE OF THE SERVICES SCHEDULED FOR THAT RESERVED TIME.

MY SIGNATURE BELOW ATTESTS THAT NO FALSE INFORMATION WAS KNOWINGLY SUPPLIED ABOVE, AND THAT I UNDERSTAND MY RESPONSIBILITIES FOR PAYMENT AND ACCEPT THE ABOVE STIPULATIONS.

SIGNED _____ DATE _____

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X _____ DATE _____

SIGNATURE OF PATIENT OR PARENT IF MINOR

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE.

I, _____, ACKNOWLEDGE THAT I HAVE RECEIVED A NOTICE OF PRIVACY PRACTICES FROM THE ABOVE-NAMED PRACTICE.

SIGNATURE: _____ DATE: _____