TLC DENTISTRY

New Patient Onboarding

A Personal Touch for A Perfect Smile

Name *

First Name Last Name

Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Email *

example@example.com

Birthdate *

Month Day Year

Cell Phone *

Please enter a valid phone number.

Social Security #

Check Appropriate Box *

- ○ Minor
- ○ Single
- ○ Married
- ○ Divorced
- ○ Widowed
- ○ Separated

Patients Employer

Work Phone

Please enter a valid phone number.

Business Address

Spouse or Parent/Guardians Name

Spouse or Parent/Guardians Phone Number

Spouse or Parent/Guardians Employer

Person to Contact in Case of Emergency *

Phone Number *

Please enter a valid phone number.

How did you find us? *

- ○ Google
- ○ Facebook
- ○ Instagram
- ○ Referred by a friend
- ○ Other

Is it the same as a Patient Information?

- ○ Yes
- ○ No

Name of Person Responsible for this Account *

Relationship to Patient *

Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Home Phone *

Please enter a valid phone number.

Cell Phone *

Please enter a valid phone number.

Email

example@example.com

Driver's License

example@example.com

Birthdate *

Month Day Year

SSN

example@example.com

Employer

example@example.com

Work Phone

Please enter a valid phone number.

Do you have dental insurance?

Please Select

Name of Insured *

First Name Last Name

Relationship to Patient *

Birthdate *

Month Day Year

SSN *

example@example.com

Date Employed

Month Day Year

Name of Employer

Work Phone

Please enter a valid phone number.

Address of Employer

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Insurance Company *

Member ID / Subscriber Number *

Group Number *

Insurance Phone Number *

Insurance Phone Number *

Insurance Company Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Do you have Additional Insurance?

- ○ Yes
- ○ No

Name of Insured

First Name Last Name

Relationship to Patient

Birthdate

Month Day Year

SSN

Date Employed

Month Day Year

Name of Employer

Work Phone

Please enter a valid phone number.

Address of Employer

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Insurance Company

Insurance Company Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Patients Name *

First Name

Last Name

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Do you have, or have you ever had, any of the following? *

- ☐ AIDS/HIV Positive
- ☐ Anaphylaxis
- ☐ Angina
- ☐ Artificial Heart Valve*
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Bruise Easily
- ☐ Chemotherapy
- ☐ Cold Sores/Fever Blisters
- ☐ Convulsions
- ☐ Diabetes
- ☐ Easily Winded
- ☐ Epilepsy or Seizures
- ☐ Excessive Thirst
- ☐ Frequent Cough
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Heart Attack/Failure
- ☐ Heart Pace Maker*
- ☐ Hemophilia
- ☐ Hepatitis B or C
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ OsteopathyOsteopenia
- ☐ Parathyroid Disease
- ☐ Radiation Treatments
- ☐ Renal Dialysis
- ☐ Rheumatism
- ☐ Shingles
- ☐ Sinus Trouble
- ☐ Stomach/Intestinal Disease
- ☐ Swelling of Limbs
- ☐ Tonsillitis
- ☐ Tumors or Growths
- ☐ Venereal Disease
- ☐ N/A
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Arthritis/Gout
- ☐ Artificial Joint*
- ☐ Blood Disease
- ☐ Breathing Problems
- ☐ Cancer
- ☐ Chest Pains
- ☐ Congenital Heart Disorder
- ☐ Cortisone Medicine
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Diarrhea
- ☐ Genital Herpes
- ☐ Hay Fever
- ☐ Heart Murmur*
- ☐ Heart Trouble/Disease
- ☐ Hepatitis A
- ☐ Herpes
- ☐ Hives or Rash
- ☐ Irregular Heartbeat
- ☐ Leukemia
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse*
- ☐ Pain in Jaw Joints
- ☐ Psychiatric Care
- ☐ Recent Weight Loss
- ☐ Rheumatic Fever*
- ☐ Scarlet Fever
- ☐ Sickle Cell Disease
- ☐ Spina Bifida
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Yellow Jaundice

*Condition may require pre-medication prior to your visit to our office

Are you under a physician care? *

- ○ Yes
- ○ No
- ○ N/A

If yes, please explain:

Have you ever been hospitalized or had a major operation? *

- ○ Yes
- ○ No
- ○ N/A

If yes, please explain:

Have you ever had a serious head or neck injury? *

- ○ Yes
- ○ No
- ○ N/A

If yes, please explain:

Are you taking any medication, pills, or prescription drugs? *

- ○ Yes
- ○ No
- ○ N/A

If yes, please list ALL the medications you use:

Are you taking any supplements? *

- ○ Yes
- ○ No
- ○ N/A

If yes, please list ALL the supplements you use:

Do you take, or have you taken, Phen-Fen or Redux? *

- ○ Yes
- ○ No
- ○ N/A

Are you on a special diet? *

- ○ Yes
- ○ No
- ○ N/A

If yes, please explain:

Do you use controlled substances? *

- ○ Yes
- ○ No
- ○ N/A

If yes, please explain:

WOMEN, are You: *

- ☐ Pregnant or trying to get pregnant?
- ☐ Nursing?
- ☐ Taking oral contraceptives?
- ☐ N/A

Are you allergic to any of the following? *

- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Acrylic
- ☐ Metal
- ☐ Latex
- ☐ Local Anesthetics
- ☐ OTHER?
- ☐ N/A

Have you ever had any serious illness not listed above? *

- ○ Yes
- ○ No
- ○ N/A

If "YES" Please specify:

Signature

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 my child or me during the period of such dental care to third party payers 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.

Signature

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.

Signature

Payment is required at the time of service unless prior arrangements have been made. You, as a patient, are responsible for the full fee of your dental treatments. We will bill your insurance as a courtesy to you. All unpaid balances over 60 days are subject to a monthly interest charge.

Signature

I also authorize to have photographs of my face, jaws and teeth taken. I understand that these items will be used as a record of my care, and may be used for educational purposes. I further understand that if these items are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature

We realize that emergencies and scheduling conflicts arise that are sometimes unavoidable. However, advance notice allows us to fulfill scheduling needs and keeps our office operating at its most efficient level. Due to reserving time and space for patient appointments, missed appointments are a significant inconvenience to your dentist, the office, and other patients. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot.
Patients are asked to arrive at their appointments before their scheduled time. A grace period of 10 minutes is permitted for unforeseen delays a patient may encounter.
A “no show” is a patient who fails to appear for a scheduled appointment without providing 48-hour notice. A rescheduled appointment that is less than the 48-hour cancellation notice is considered a cancellation and treated as such. There is a $50 charge per hour of scheduled treatment cancelled. This charge must be paid on or before the next scheduled appointment.
Should a patient continue to break appointments, we reserve the right to dismiss that patient from the practice.

Signature

Please check any of the following problems that apply to you. *

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, earaches, neck pain
- ☐ Jaw joint pain
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth
- ☐ N/A

Do you have or have you had any of the Close spaces following: *

- ☐ Dentures
- ☐ Partial denture
- ☐ Braces
- ☐ Periodontal (gum) treatments
- ☐ N/A

Are you interested in whiter teeth? *

- ○ Yes
- ○ No
- ○ I would like more information
- ○ N/A

Do you smoke or use chewing tobacco?

- ○ Yes
- ○ No

How much?

How long?

If you could change your smile, you would:

- ☐ Make it brighter
- ☐ Make it straighter
- ☐ Replace black metal fillings with tooth Dentures colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

When was your last dental cleaning?

When was your last oral cancer screening?

When was your last complete dental x-rays? *

- ○ Last year
- ○ 2 years ago
- ○ 3 years ago
- ○ 4 years ago
- ○ 5+ years ago
- ○ Not Sure

How important is your dental health to you?

	1	2	3	4	5	
Worst	○	○	○	○	○	Best

Where would you rate your current dental health?

	1	2	3	4	5	
Worst	○	○	○	○	○	Best

Why did you leave your previous dentist? *

What is the most important thing to you about your dental visit?

Anything else you want us to know?