Welcome to Cline Dental Group

Thank you for selecting our dental healthcare team!
To help us meet all of your dental and health needs, please complete both sides of this form.
If you have any questions, please ask - we will be happy to help.

Today's date:		Home Phone: ( )	
PATIENT INFORMATION			
Patient's Name:		❑ Female ❑ Male	Marital status (circle one):
Preferred or Nickname:			Single / Mar / Div / Sep / Widowed
Date of Birth:	Patients Age:	SS#:	
Home Address:	City:	State:	Zip:
Cell Phone: ( )	Email Address (optional):		
If Student, Name of School/College:		Student Status: ❑ Full-time ❑ Part-time	
Patient or Parent/Guardian's Employer:		Work Phone: ( )	
Spouse's Name:	Spouse's Daytime Phone:		
Person Responsible for Account, Please Check One: ❑ Self ❑ Guardian ❑ Father ❑ Mother			
How did you select our office? (please check one box): ❑ Family ❑ Friend ❑ Close to home/work ❑ Insurance Plan ❑ Yellow Pages ❑ Other_____			
Other family members seen here:			
Whom may we thank for referring you:			
INSURANCE INFORMATION			
(Please give your insurance card to the receptionist.)			
Subscriber's Name:	Relationship to Patient:		
Subscriber's Date of Birth:	Subscriber's SS#:	Daytime phone: ( )	
Subscriber's Employer:	Union/ Local #:	Work Phone: ( )	
Is this person a patient here? ❑ Yes ❑ No			
Insurance Company:	Insurance Co. Phone: ( )		
ID# or Policy#:	Group #:		
SECONDARY INSURANCE INFORMATION			
DO YOU HAVE ADDITIONAL INSURANCE? ❑ YES ❑ NO IF YES, COMPLETE THE FOLLOWING:			
Subscriber's Name:	Relationship to Patient:		
Subscriber's Date of Birth:	Subscriber's SS#:	Daytime phone: ( )	
Subscriber's Employer:	Union/Local #:	Work Phone: ( )	
Is this person a patient here? ❑ Yes ❑ No			
Insurance Company:	Insurance Co. Phone: ( )		
ID# or Policy#:	Group #:		
IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):			
Relationship to patient:	Home Phone: ( )	Daytime Phone: ( )	

Patient Name_____ **Date**_____

Patient Medical History

Do you have any current health problems? ❑ Yes ❑ No
Are you under a physicians care now? ❑ Yes ❑ No
If yes, please explain_____
_____

Physician name/phone #_____

What medications are you currently taking?_____
_____
_____

Are you currently taking or have you ever taken Fosamax or any other bone density medications: ❑ Yes ❑ No
Do you use tobacco? ❑ Yes ❑ No

Women only:
Are you taking oral contraceptives? ❑ Yes ❑ No
Are you pregnant or think you may be pregnant? ❑ Yes ❑ No
If yes, how many months?_____

Patient Dental History

DATE of last DENTAL VISIT? _____
DATE of last FULL MOUTH X-RAYS? _____
Name of Previous Dentist (optional) _____

Do you currently have any PAIN in your mouth or jaw?	❑ Yes	❑ No
Are your teeth SENSITIVE to hot, cold, sweets, pressure?	❑ Yes	❑ No
Do your gums BLEED, or feel TENDER or IRRITATED?	❑ Yes	❑ No
Have you ever had any PERIODONTAL (GUM) treatment?	❑ Yes	❑ No
Would you like your smile to LOOK BETTER or DIFFERENT?	❑ Yes	❑ No
Are you aware of GRINDING or CLENCHING your teeth?	❑ Yes	❑ No
Do you have HEADACHES, EARACHES, or NECK PAINS?	❑ Yes	❑ No
Have you worn BRACES on your teeth? (ORTHODONTICS)	❑ Yes	❑ No
Do you feel NERVOUS about having dental treatment?	❑ Yes	❑ No
Do you REGULARLY use DENTAL FLOSS?	❑ Yes	❑ No
Does food CATCH between any of your teeth?	❑ Yes	❑ No
Do you have any CLICKING or POPPING in your jaw?	❑ Yes	❑ No
Do you feel you have BAD breath?	❑ Yes	❑ No
Would you like to have WHITER TEETH?	❑ Yes	❑ No

Primary reason for this Dental Appointment (please circle):
Examination/Checkup Emergency Consultation

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING:

	Yes	No		Yes	No
High Blood Pessure	❑	❑	Cancer	❑	❑
Heart Disease	❑	❑	Radiation Treatment	❑	❑
Heart Attack	❑	❑	Stroke	❑	❑
Heart Murmur	❑	❑	Glaucoma	❑	❑
Rheumatic Fever	❑	❑	Angina	❑	❑
Cardiac Pacemaker	❑	❑	Frequently Tired	❑	❑
Swollen ankles	❑	❑	STD/Venereal Disease	❑	❑
Liver Disease	❑	❑	Hepatitis A	❑	❑
Joint Replacement	❑	❑	Hepatitis B	❑	❑
Kidney Diseases	❑	❑	Stomach Troubles/ Ulcers	❑	❑
Thyroid Problems	❑	❑	Respiratory Problems	❑	❑
Diabetes	❑	❑	Emphysema	❑	❑
Leukemia	❑	❑	Recent Weight Loss	❑	❑
Epilepsy/Convulsions	❑	❑	Drug/Alcohol Addiction	❑	❑
Asthma	❑	❑	Tuberculosis	❑	❑
Fainting/Seizures	❑	❑	Hemophilia	❑	❑
Psychiatric Treatment	❑	❑	AIDS/HIV Pos.	❑	❑
Blood Thinning Medication	❑	❑	Other_____	❑	❑

ARE YOU ALLERGIC TO OR HAVE YOU EVER REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS/MATERIALS?
(please circle all that apply)

Latex Rubber	Erythromycin
Local Anesthetics	Penicillin
Sulfa Drugs	Metals (nickel, etc.)
Aspirin	Codeine
Nitrous Oxide	Iodine
Barbiturates	None of the Above

Are your aware of being allergic to other medications or substances? ❑ Yes ❑ No
If yes, please specify: _____
_____

Is there any other Medical or Dental Information that you feel we should know about? ❑ Yes ❑ No
If yes, please specify: _____

Authorization and Release

I certify that I have read and understand the above information and have answered the questions to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health and/or the health of my dependents. I hereby authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents 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, regardless of any estimates made by the doctor or employees of Cline Dental Group. In the case of default of payment, I understand that I am responsible for any collection costs and/or attorney fees incurred to effect collection of this account or future outstanding accounts.

_____ _____
Patient/Guardian/Responsible Party Signature Date