TRITON DENTAL

WELCOME

We want to thank you for choosing us, as partners in achieving your healthcare goals. Please fill out this form completely and accurately.

1 ABOUT YOU

Today's Date: _____

Email Address: _____

Name: _____

I prefer to be called: _____ o Male o Female

B/D: ___/___/_____ Driver's License #:_____ SIN:_____

Home Address: _____

_____

o Single o Married o Divorced o Widowed o Separated

Hm #: (____)_____ Cell #: _____

Wk #: (____)_____ Ext: _____

Where & when are best times to reach you? _____

Employer: _____

How long there? _____ Occupation: _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Last Dentist Visit Date: _____

2 PARENT INFORMATION

His/Her Name: _____

Employer: _____

Hm #: (____)_____ Wk #: (____)_____

Person Responsible for Account: _____

Hm #: (____)_____ Wk #: (____)_____ Ext: ____

Billing Address: _____

Relation: _____ SIN: _____

Employer: _____ DL #: _____

? In the event of an emergency, is there someone who lives near you that we should contact?

His/Her Name: _____

Relation: _____ Cell #: _____

Hm #: (____)_____ Wk #: (____)_____

3 INSURANCE COVERAGE

Do you have dental coverage? o Yes o No

Insurance Co. Name: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's B/D: ___/___/_____ Insured's ID# : _____

Insured's Employer: _____

Second Insurance? o Yes o No

4 DENTAL HISTORY

Why have you come to the dentist today?

_____

_____

Are you currently in pain? o Yes, o No

Do you require antibiotics before dental treatment? o Yes, o No

Do your gums ever bleed? o Yes o No

Have you ever had a serious/difficult problem associated? with any previous dental work? o Yes o No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? o Yes o No

Do you like your smile?

Your current dental health is: o Good o Fair o Poor

Do you grind your teeth? o Yes, o No

Would you like whiter teeth? o Yes o No

Would you like fresher breath? o Yes o No

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of bristles? o Soft o Medium o Hard

Do you smoke or use tobacco in any other form? o Yes o No

CONTINUED ON BACK

5

MEDICAL HISTORY

Do you have a personal physician? o Yes o No

Physician's Name: _____

Phone #: (___)_____ Date of last visit: _____

Are you currently under the care of a physician? o Yes o No

Please explain: _____

Your current physical health is: o Good o Fair o Poor

Are you taking any prescription/over-the-counter or herbal supplement drug? o Yes o No

Please list each one: _____

_____

Have you ever taken Fosamax, or any other bisphosphonate? o Yes o No

Have you ever taken Phen-fen? o Yes o No

For Women

Are you using a prescribed method of birth control? o Yes o No

Are you pregnant? o Yes o No Week #:_____

Are you nursing? o Yes o No

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Hepatitis
Y	N	Alcohol/Drug Abuse	Y	N	Herpes/Fever Blisters
Y	N	Anemia	Y	N	High Blood Pressure
Y	N	Angina	Y	N	HIV+/AIDS
Y	N	Arthritis	Y	N	Hospitalized for Any Reason
Y	N	Artificial Bones/Joints/Valves	Y	N	Human Papilloma Virus
Y	N	Asthma	Y	N	Kidney Problems
Y	N	Blood Transfusion	Y	N	Leukemia
Y	N	Cancer/Chemotherapy	Y	N	Liver Disease
Y	N	Chest Pain	Y	N	Low Blood Pressure
Y	N	Colitis	Y	N	Pacemaker
Y	N	Diabetes	Y	N	Radiation Treatment
Y	N	Difficulty Breathing	Y	N	Recent Weight Loss
Y	N	Emphysema	Y	N	Respiratory Problems
Y	N	Epilepsy	Y	N	Seizures
Y	N	Fainting Spells	Y	N	Sexually Transmitted Diseases
Y	N	Frequent Headaches	Y	N	Shingles
Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Hay Fever	Y	N	Smoke
Y	N	Heart Attack	Y	N	Stroke
Y	N	Heart Disease	Y	N	Thyroid Problems
Y	N	Heart Surgery	Y	N	Tuberculosis (TB)
Y	N	Hemophilia	Y	N	Ulcers

MEDICAL HISTORY *continued*

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Iodine	Y	N	Penicillin
Y	N	Codeine	Y	N	Latex	Y	N	Sedatives
Y	N	Dental Anaesthetics	Y	N	Metals	Y	N	Sulpha Drugs

Please list any other drugs/materials that you are allergic to:

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in my medical status. I authorize the dentist to release my information including the diagnosis and treatment records of mine or my child to third-party payors and/or health practitioners and for educational purposes. I authorize the dentist and staff to perform anynecessary dental services that I may need during diagnosis andtreatment with my informed consent.

Signature: _____ **Date**:_____

Payment is due in full at the time of treatment unless prior arrangements have been approved.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

I authorize my insurance company to pay directly to the dentist benefits otherwise payable to me.

Appointments altered or cancelled without 48hrs notice will incur $75 fees, and I understand it is not covered by insurance.

Signature _____ **Date** _____

OFFICE USE ONLYOFFICE USE ONLY**OFFICE USE ONLY**OFFICE USE ONLY**OFFICE USE ONLY**

I verbally reviewed the medical/dental information above with the patient named herein. Initials: _____ Date: _____

Dentist's Comments: _____