Welcome

PATIENT INFORMATION		
PATIENT'S NAME (Last, First, M.I.):		
MARITAL STATUS: ☐ SINGLE ☐MARRIED	SPOUSE NAME:	
HOME ADDRESS (Street, City, State, Zip):		
BIRTHDATE:	AGE:	SOCIAL SECURITY #:
EMAIL		
HOME PHONE #:	CELL PHONE#	
WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?		
REASON FOR THIS VISIT:		
PHYSICIAN'S NAME:	PHONE #:	
PHYSICIAN'S ADDRESS:		
IN CASE OF EMERGENCY NOTIFY:	RELATIONSHIP AND PHONE NUMBER:	

RESPONSIBLE PARTY INFORMATION	
NAME (Last, First, M.I.):	MARITAL STATUS: ☐ SINGLE ☐ MARRIED
BIRTHDATE:	DRIVER'S LICENSE #:
SOCIAL SECURITY#:	OCCUPATION:
EMPLOYER:	EMPLOYER ADDRESS:
RELATIONSHIP TO PATIENT:	WORK PHONE:
BILLING ADDRESS (If different from above):	

PRIMARY INSURANCE INFORMATION	
SUBSCRIBER'S NAME:	RELATIONSHIP TO PATIENT:
SUBSCRIBER'S ADDRESS:	SUBSCRIBER'S PHONE #:
SUBSCRIBER'S SOCIAL SECURITY #:	SUBSCRIBER'S EMPLOYER:
INSURANCE COMPANY:	
INSURANCE COMPANY ADDRESS	
INSURANCE COMPANY PHONE #:	
ID NUMBER:	GROUP NUMBER:

CERTIFICATION OF PAYMENT

I accept responsibility for paying all balances due at the time of service. In the event the account becomes delinquent, I accept responsibility for paying interest and collection fees arising as a result of my failure or delinquency in settling this debt, as well as all legal fees incurred pursuant to obtaining payment.

I hereby authorize payment directly to Auburn Plaza Dental (Dr. Adebayo Aliu) of the group insurance benefits otherwise payable to me.

Patient/Guardian's Signature Date	**Doctor's Signature Date**

If patient is covered by additional insurance, please fill out the secondary insurance information

SECONDARY INSURANCE INFORMATION	
SUBSCRIBER'S NAME:	RELATIONSHIP TO PATIENT:
SUBSCRIBER'S ADDRESS:	SUBSCRIBER'S PHONE #:
SUBSCRIBER'S SOCIAL SECURITY #:	SUBSCRIBER'S EMPLOYER:
INSURANCE COMPANY:	
INSURANCE COMPANY ADDRESS	
INSURANCE COMPANY PHONE #:	
ID NUMBER:	GROUP NUMBER:

CERTIFICATION OF PAYMENT

I accept responsibility for paying all balances due at the time of service. In the event the account becomes delinquent, I accept responsibility for paying interest and collection fees arising as a result of my failure or delinquency in settling this debt, as well as all legal fees incurred pursuant to obtaining payment.

I hereby authorize payment directly to Auburn Plaza Dental (Dr. Adebayo Aliu) of the group insurance benefits otherwise payable to me.

Patient/Guardian Signature **Date**	**Doctor's Signature** **Date**

Medical History

Patient Name:_____ Date:_____

MEDICAL HISTORY: Certain illnesses and drugs may make it necessary to alter our treatment. In our endeavor to render the best possible health care to you (or your child), it is necessary to have the following information. Have you (the patient) ever had or do you now have the following, if yes, please indicate "yes" by checking/circling or writing in all illnesses or conditions that apply.

	YES	NO
AIDS / HIV Positive	☐	☐
Allergies Allergy to penicillin, aspirin, local and general anesthetic or other drugs or materials such as latex.	☐	☐
Arthritis / Rheumatism (painful, swollen joints)	☐	☐
Asthma	☐	☐
Bleeding or Clotting Disorders	☐	☐
Cancer	☐	☐
Cerebral Vascular Accident (stroke)	☐	☐
Congenital Heart Conditions (ventricular or atrial septal defect, hypertrophic cardiomyopathy	☐	☐
Diabetes	☐	☐
Epilepsy	☐	☐
Hay fever, Hives, Skin Rash	☐	☐
Heart Murmur	☐	☐
Heart Valve Replacement or Stent Placement	☐	☐
Hepatitis or Jaundice	☐	☐
Herpes	☐	☐
High Blood Pressure	☐	☐
Hip Replacement or Prosthetic Joint Replacement	☐	☐
Infective Endocarditis	☐	☐
Kidney Trouble / Dialysis	☐	☐
Liver Trouble	☐	☐
Mitral Valve Prolapse	☐	☐
Organ Transplant	☐	☐
Pacemaker or Open Heart Surgery	☐	☐
Psychiatric Disorders	☐	☐
Respiratory Disorders / Emphysema	☐	☐
Rheumatic Fever	☐	☐
Sinusitis or Other Allergies	☐	☐
Substance Abuse (Past or Current)	☐	☐
Thyroid problems	☐	☐
Tuberculosis	☐	☐
Ulcer or Stomach Problems	☐	☐

Any other illness? ____ Yes____No If yes, please specify_____

Are you presently taking any Medicine? ____Yes ___No If yes, please list._____

_____

_____

Do you smoke? _____ Yes _____ No
If yes, how much do you smoke in a day?_____

Do you drink? _____ Yes _____ No
If yes, how much do you drink?
_____

Do your wounds heal slowly? _____ Yes _____ No

Are you presently under the care of a physician? ___No ___ Yes

When was your last physical exam?_____

Have you ever been hospitalized? ___ No ___Yes
If yes, Date:_____
Reason:_____

Have you had any x-ray treatments or chemotherapy? ___ No ___Yes

Have you ever taken the diet drug Phen Phen? ____No ____Yes

Are you taking birth control pills? ___No ___Yes

Are you pregnant? ____ No ____ Yes If yes, how far along are you _____

Patient/Guardian Signature _____ Date_____

Doctor's Signature_____Date_____

At Second Cleaning Appointment for the Year ONLY:

Has there been any changes to your health ____No ____Yes

Patient/Guardian Signature _____ Date_____

Doctor's Signature_____Date_____

Auburn Plaza Dental
Dental History

Patient Name: _____ Date: _____

1. Are you experiencing any of the following symptoms? If yes, please check all that apply.

___ Sensitive teeth	___Sore jaw	___Toothache
___ Bleeding gums	___Difficulty chewing	___Filling fell out
___ Bad breath	___Burning sensation	___Abscess
___ Swelling inside mouth	___Tartar build-up	___Yellowing teeth
___ Sore gums	___Dry mouth	___Swollen face
___ Difficulty swallowing		

Comments:_____
_____

2. When was your last dental

Exam_____ Cleaning_____

3. Do you clench or grind your teeth in the day time or at night?
___ Yes ___No If yes, do wear a night guard? ___ Yes ____No

If yes, how long have you been wearing a night guard_____

4. Are you concerned about the appearance of your teeth? If yes, please check all that apply.

____Yellowing/graying teeth	____Stains	____Crowded/crooked
____Spacing between teeth	____Other_____	

5. Check any of the following you regularly use at home

____Soft toothbrush	____Dental floss	____Floss threader
____Hard toothbrush	____Fluoride toothpaste	____Fluoride rinse or gel
____Medium toothbrush	____Rubber tip stimulator	____Mouth rinse
____Oral irrigator	____Denture cleanser	____Whitening product
____Electric toothbrush	____Battery toothbrush	____Other_____

6. How often to you brush_____

7. How often to you floss_____

8. Generally, how have you felt about your previous dental appointments?

___Very anxious and afraid
___Somewhat anxious and afraid
___Don't care one way or the other
___Enjoy my appointments and look forward to it

9. Do you have pain, popping, and or clicking in your jaw or near your ears? _____ Yes _____No

10. Do you have a bad taste in your mouth or mouth odor? _____Yes _____ No

11. Is there any other problem not covered above that you would like to discuss? ____Yes _____ No
If yes, please state below:

_____

_____