Welcome To Our Office

Dr. Nichols
Family Dentistry

Date______________________________

Name:____

Address:______________________________City____________________State___________Zip__________

Phone:#_______________________ Cell:#_______________________ Work:#________________________

Date of Birth: ___________________________________Social Security Number:_____________________

Employer: ____

Spouse Name: ____

Spouse Employer: ____

Spouse Social Security Number: ____

Dental Insurance Carrier: ____

Spouse Dental Insurance Carrier: ____

Person financially responsible for account: ____

How will you be paying today? Cash , Check , or Credit Card _____________________________________

Who should we thank for referring you? ____

DENTAL INFORMATION

Please Circle One

Are you having any discomfort at this time?.. YES NO

How long since your last dental visit?____

Have you ever been treated for gum disease?...YES NO
If so, When? ________________________________

How often to you brush?________/day floss ________/day

Do you have or have you had any of the following: **Please Circle One**

Bleeding, sore gums	YES	NO	Frequent blistered lips, mouth	YES	NO
Unpleasant taste/bad breath	YES	NO	Swelling, lumps in mouth	YES	NO
Burning tongue/lips	YES	NO	Clicking, popping in jaw	YES	NO
Loose teeth	YES	NO	Food impaction	YES	NO
Sensitive teeth	YES	NO	Clenching/grinding	YES	NO

Please continue on back

Medical Information

Do you have or have you had any of the following: **Please Circle One**

Condition		
Rheumatic fever or rheumatic heart disease	YES	NO
Congenital heart disease	YES	NO
Cardiovascular disease (heart trouble, heart attack)	YES	NO
Artificial or replacement valves	YES	NO
Pacemaker	YES	NO
Sinus trouble	YES	NO
Asthma or hay fever	YES	NO
Hives or skin rash	YES	NO
Fainting spells or seizures	YES	NO
Diabetes	YES	NO
Hepatitis, jaundice or liver disease	YES	NO
Arthritis or inflammatory rheumatism	YES	NO
Artificial or replacement joints	YES	NO
Digestive system disorders (stomach ulcers, colitis)	YES	NO
Kidney trouble	YES	NO
Tuberculosis	YES	NO
Persistent cough or cough up blood	YES	NO
Immune system disorders (including AIDS, HIV, ARC)	YES	NO
Venereal disease	YES	NO
Mental illness	YES	NO
Do you require antibiotics before dental treatment?	YES	NO
Have you had any medical problems following dental procedures?	YES	NO
Do you use any tobacco products?	YES	NO
Do you use any alcohol products?	YES	NO

Please list any allergies: ______________________________

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Please list all medications: ______________________________

including aspirin and non-prescription: ______________________________

Name and address of physician: ______________________________

Are you pregnant?: Yes No

SIGNATURE: ______________________________

This information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

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Signature

PAYMENT IS DUE AT TIME OF SERVICE

I assign directly to Dr. Nichols insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure that payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

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Signature