Pearl Shine Dental

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Patient Information

Patient Last Name _____ Patient First Name _____ Preferred Name (If any) _____ Date of Birth _____

Social Security # _____ Drivers License _____ Employer Name _____ Occupation _____

Address _____ City _____ State _____ Zip Code _____

Cell Phone _____ Home Phone _____ Work/Other _____

E-Mail Address _____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Child

How did you hear about us? _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name _____ Relationship _____

Cell Phone _____ Home Phone _____ Work/Other _____

Parent/Legal Guardian Information (If patient is minor)

Parent's marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single Relation: _____

Parent Full Name _____ Date of Birth _____

Address (If different than above) _____ City _____ State _____ Zip Code _____

E-Mail Address _____ ☐ Male ☐ Female

Insurance Information

Subscriber's Name _____ Subscriber Date of Birth _____ Subscriber ID/SSN# _____

Employer Name _____

Insurance Address _____ Insurance Phone Number _____

Patient Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

As a policy, financial arrangements must be made prior to your treatment. All dental emergency services must be paid in full, if insurance company cannot be contacted at the time of services. **Authorization and Release:** I authorize and request my insurance company to pay, Pearl Shine Dental, the insurance benefits. I authorize Pearl Shine Dental to release all information necessary to secure payment of benefits. **I understand that the treatment plan I receive is only an estimate and that I am financially responsible for any unpaid balances that the insurance does not pay.**

_____ _____

Patient and/or Legal Guardian/Parent Signature **Date**

Reason for today's visit: _____

Name of Previous Dentist: _____ Date of your last dental visit: _____

Have you had complications following dental treatment? Y N

If yes please explain: _____

Would you change anything about the appearance of your teeth? Y N

If yes please explain: _____

Do you smoke or chew tobacco Y N Do you use Alcohol Y N

Do you have any of the following dental condition?

Bad Breath	Y N	Sore or Growth	Y N	Sensitive to hot cold or biting	Y N
Bleeding Gums	Y N	Clicking or Popping jaw	Y N	Periodontal Treatment	Y N
Grinding Teeth	Y N	Loose teeth or broken filling	Y N	Food caught between teeth	Y N

Do you have or have had any of the following medical conditions?

Allergies	☐Y ☐ N	Liver Disease Hepatitis A, B, C/ Jaundice	☐Y ☐ N
Congenital Heart Disease	☐Y ☐ N	Kidney Disease	☐Y ☐ N
Cardiovascular Disease	☐Y ☐ N	Diabetes	☐Y ☐ N
High/ Low Blood Pressure	☐Y ☐ N	Thyroid Disease	☐Y ☐ N
Heart Murmur/ Mitral Valve Prolapse	☐Y ☐ N	Stomach Ulcer/ Colitis	☐Y ☐ N
Heart Attack / Angina	☐Y ☐ N	Arthritis	☐Y ☐ N
Stroke	☐Y ☐ N	Glaucoma	☐Y ☐ N
Pacemaker	☐Y ☐ N	Artificial Heart Valve	☐Y ☐ N
Heart Surgery	☐Y ☐ N	Artificial Joint (Hip/ Knee)	☐Y ☐ N
Rheumatic Fever/ Rheumatic Heart Disease	☐Y ☐ N	HIV/ AIDS	☐Y ☐ N
Respiratory Disease	☐Y ☐ N	STD (Sexually Transmitted Disease)	☐Y ☐ N
Asthma	☐Y ☐ N	Radiation/ Chemotherapy for Cancer	☐Y ☐ N
Emphysema	☐Y ☐ N	Bleeding Disorder/ Anemia/ Blood Transfusion	☐Y ☐ N
Pneumonia	☐Y ☐ N	Seizures/ Epilepsy/ Fainting/ Psychiatric Treatment	☐Y ☐ N
Tuberculosis	☐Y ☐ N	Dizziness/ Nervous Disorder	☐Y ☐ N
Shortness of Breath	☐Y ☐ N	Any Disease, Drugs, or Transplant operation that	
Chest Pain	☐Y ☐ N	has depressed your Immune System	☐Y ☐ N

Physician's name: _____ Phone number: _____

Are you under Physician's care?

If yes, explain: _____

Women: Are you pregnant? Y N Are you Breast feeding? Y N Are you taking Birth Control Pills? Y N

Have you been hospitalized or needed emergency care in the past two years? Y N

If yes explain:

_____

List of any Medications: **(If none put "NONE")**

_____

_____

Are you allergic (if none put "none") to: ☐ Penicillin ☐ Codeine ☐ Latex ☐ Iodine ☐ Sulfa ☐ Other _____

_____

I understand that honest answers to the questions stated below are important to the provision of my dental care, and that I will answers them best of my ability. I have been informed that if I am uncertain about the question or how the question relates to my health status I must discuss the problem with the doctor or a member of the staff. I understand that all questions must be answered. I have been assured that the information I provide will not be released without my express permission. To the Best of my knowledge, all of the following information is correct and true.

I understand that should there be a change in my health during my dental treatment, I am to inform the dentist at the earliest possible time.

_____ _____ _____

Patient/ Guardian/ Parent Signature Date Doctor's Initials