Boain Dental Care
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Welcome

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Thank you for choosing our practice for your dental needs. The benefits of a happy healthy smile are immeasurable. Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you and your family.

About You:

Name _____ Mr Mrs Ms Dr
I prefer to be called _____ male female
Birth date ___/___/___ SS# _____
Home Address _____
_____
Hm phone # _____ Cell # _____
Wk phone # _____ e-mail _____
I prefer to receive calls home work cell
I am: minor married single divorced
widowed
You/your parents employer _____
Occupation _____
Business Address _____
Whom may we thank for referring you?
_____
Other family members seen by us _____
_____

Spouse or Parent Information

Name _____
Relationship _____ Wk Phone# _____
SS# _____
Name _____
Relationship _____ Wk Phone# _____
SS# _____
Person responsible for account _____
Relationship _____
Phone and address if different than yours _____
_____
Employer _____ Wk # _____
SS# _____ Birth date __/__/___

Dental Insurance:

Name of insured _____
Relationship _____ SS# _____
Insured's employer _____
Insurance Co. Name _____
Insurance Co. Address _____
_____
Group # _____ ID# _____
Deductible _____ Maximum _____
Used this year _____ Last claim _____
Last dental x-rays _____

Secondary Insurance:

Name of insured _____
Relationship _____ SS# _____
Insured's employer _____
Insurance Co. Name _____
Insurance Co. Address _____
_____
Group # _____ ID# _____
Deductible _____ Maximum _____
Used this year _____ Last claim _____
Last dental x-rays _____

Emergency contact information:

Name _____
Relationship _____
Wk# _____ Hm# _____
Address _____
Neighbor or Relative not living with you:
Name _____
Relationship _____
Wk# _____ Hm# _____
Address _____

Confidential

Dental History

Your chief concerns and purpose of your visit today:

_____

_____

What is most important to you in choosing a dental home? _____

What is most important to you in your dental health?

_____

Is there anything you would change about your smile?

_____

Do you experience a bad taste in your mouth? _____

Previous Dentist _____

Date of last exam and x-rays _____

Have you ever had an unpleasant dental experience?

_____

Have you had: orthodontics _____ date _____

Periodontal therapy _____ date _____

Teeth extracted _____

Please check any of the following that apply to you or your child:

- ○ Bad breath
- ○ Clicking/popping jaw
- ○ Snoring
- ○ Grinding teeth
- ○ Bleeding gums
- ○ Thumb sucking
- ○ loose/broken fillings
- ○ sensitivity to cold
- ○ sensitivity to hot
- ○ oral sores or growths
- ○ canker sores
- ○ fever blisters

Please add anything you feel is important:

_____

_____

Medical History:

Physician's Name _____

Phone # _____ Date of last exam _____

Pharmacy _____ Phone _____

Do you smoke or use tobacco in any form? _____

Medical History Cont.:

For women: Are you taking birth control pills? _____

Are you pregnant? _____ Nursing? _____

Have you ever or do you currently have any of the following?

- ☐ Abnormal Bleeding
- ☐ ADD/ADHD
- ☐ Alcohol/Drug Abuse
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial joints/limbs
- ☐ Artificial heart valve
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer-chemotherapy
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Cosmetic Surgery
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever/allergies
- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis A B C
- ☐ High Blood Pressure
- ☐ HIV+/AIDS
- ☐ Jaw pain
- ☐ Hospitalization_____
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pace maker
- ☐ Pneumocystitis
- ☐ Psychiatric Problems
- ☐ Radiation therapy_____
- ☐ Rheumatic/Scarlet fever
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐Venereal Disease
- ☐Yellow Jaundice

Please list any serious medical conditions you have ever had:

_____

_____

Are you allergic to any of the following:

- Y N Aspirin
- Y N Codeine
- Y N Dental Anesthetics
- Y N Erythromycin
- Y N Latex
- Y N Penicillin
- Y N Tetracycline
- Y N Sulfa drugs
- Y N Other _____

_____

Please list all medications you are currently taking:

_____

_____

_____

I certify that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in strictest confidence and it is my responsibility to inform this office of any change in my/my child's medical status. _____ Date _____

I certify that I/my child is covered by the above insurance and I assign directly to Boain Dental Care all insurance benefits otherwise payable to me. I understand that I am responsible for the payment of services rendered. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ Date _____

I authorize the dental staff to perform the necessary dental services I/my child may need; however, I understand I will be informed prior to treatment. _____ Date _____

I give Boain Dental Care permission to use my photos for patient education and as a teaching aid as well as before and after dental treatment on www.boaindentalcare.com and other advertising endeavors. I understand my name and personal information will not be shared. _____ Date _____