

Personal Information Form

Date: _____ Patient's First Name: _____ Last Name: _____ Nickname: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Sex: M F Age: _____ Birth Date: ___/___/___ Single Married Widow Separated Divorced SS#: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

E-mail Address: _____ **How did you first hear about our office:** _____

Do we have your permission to send you occasional correspondence on informative dental topics as well as reminders of your appointments via email or text through our automated system? You may opt out at any time. Yes No

If the person responsible for this payment is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section entitled "Insurance Information".

Name of Responsible Party: _____ Relationship to Patient: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Sex: M F Age: _____ Birth Date: ___/___/___ Single Married Widow Separated Divorced SS#: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Email Address: _____

Employer: _____ Occupation: _____

Insurance Information

Policy Holder's Name: _____ Relationship to Patient: _____ SS#: _____ DOB: ___/___/___

Name of Employer: _____ Employer Address: _____

Insurance Co.: _____ Group #: _____ Address: _____

Secondary Insurance Information

Policy Holder's Name: _____ Relationship to Patient: _____ SS#: _____ DOB: ___/___/___

Name of Employer: _____ Employer Address: _____

Insurance Co.: _____ Group #: _____ Address: _____

Family Member Information

Please list the names of your spouse and children	Is person a patient		Sex		Age	Date of Birth (mm/dd/yyyy)
	Yes	No	M	F		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Please list the names of your spouse and children	Is person a patient		Sex		Age	Date of Birth (mm/dd/yyyy)
	Yes	No	M	F		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

I certify that all of the information (including medical health history, personal, and insurance records) is true and complete. I understand that Mercer Smiles will assist me in filing my claims, but the insurance coverage I have for dental services can vary and will depend on my insurance plan. I understand that I am responsible for all fees and services. Since our doctors often provide continuing education to other doctors, I give my permission to use my photos for educational purposes. I have read and agree to your HIPAA Notice of Privacy Practices.

If the patient is a minor, as the responsible party I give permission, in my absence, to provide examinations, dental cleanings and necessary x-rays as part of routine care for this patient.

Signature of Patient (Responsible Party if a minor): _____

Medical and Dental Health History Form

Patient's Name: _____ Previous Dentist Office: _____

History of Dental Radiographs: Panoramic Bitewings * If marked, indicate date when x-rays were taken: _____

Medical Doctor's Name: _____ Doctor's Phone #: _____ Date of last completed physical: _____

Doctor's Address: _____ City: _____ State: _____ Zip: _____

Are you taking any medication, vitamins or supplements? Yes No

If yes, please list: _____

For what purpose? _____

Rate your medical health: Excellent Good Fair Poor

Are you pregnant? Yes No If yes, how many months: _____

Are you allergic or react to: Penicillin Codeine Local injected Anesthetic Latex Other _____

Have you ever been told that because of this you need to take antibiotics prior to dental cleanings or other treatment? Yes No

Have you had any surgeries or hospitalizations: _____

Do you have or have you ever had any of the following:

Abnormal Bleeding Yes No

AIDS or HIV Infection Yes No

Anemia Yes No

Arthritis Yes No

Blood Transfusion Yes No

Cancer/Chemotherapy/Radiation Yes No

Cardiovascular Disease Yes No

If yes please specify: _____

Heart Attack Yes No

Diabetes Yes No

Eating Disorder Yes No

Epilepsy Yes No

Fainting spells or seizures Yes No

Gastrointestinal Disease Yes No

Glaucoma Yes No

Hemophilia Yes No

Mental Health Disorders Yes No

If yes please specify: _____

Osteoporosis Yes No

Respiratory Problems Yes No

Severe Headache/Migraines Yes No

Rapid Weight Loss/Gain Yes No

Sexually Transmitted Disease Yes No

Sinus Trouble Yes No

Sleep Disorder Yes No

Sore or Ulcers in Mouth Yes No

Stroke Yes No

Lupus Yes No

Tuberculosis Yes No

Thyroid Problems Yes No

Ulcers Yes No

Ulcerative Colitis Yes No

** Do you have any disease, condition, or problem not listed above?

Please Explain: _____

Do you smoke: Yes No *If marked yes, if so how much? _____

Do you drink alcohol: Yes No *If marked yes, if so how much? _____

Do you use recreational drugs? Yes No *If marked yes, what kind? _____

Do you ever get: Stress headaches Migraines Ear pain T M Joint pain Sensitive teeth clicking in Jaw Joints Hard to chew or pain with chewing

General Dental Health and Concerns

What's most important to you about your teeth? _____

How would you rate your dental health? Excellent Good Fair Poor

What is the main barrier to your dental health being better? Fear Time Costs Other _____

Is keeping your teeth important to you? Yes No If yes, why? _____

Does having dental work make you feel anxious, nervous, or fearful? Yes No

How can we help you with any issues? _____

Do you have any: Discomfort in teeth or mouth Bleeding gums bad breathe Food traps around teeth?

Dental Appearance

How would you rate the appearance of your smile from 1-10? _____

If you could make any changes about your dental appearance what would be important to you:

Whiten Teeth

Create a more youthful looking smile

Replacing missing teeth

Close spaces between teeth

Replace discolored or old looking crowns

Repair worn, chipped or broken teeth

Remove silver fillings for health reasons

Straighten teeth with braces or Invisalign