Welcome

Springwood Dental Associates

Our goal is to help you reach and maintain Maximum dental health. **Please fill out these forms completely.** The better we communicate, the better we can care for you.

ABOUT PATIENT

MR □ MRS □ MS □ DR □
Name: _____ Name I prefer to be called: _____Today's Date_____
Date of Birth: ___/___/___ Male □ Female □ Social Security Number: _____
Address: _____
City/State: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ ___Email Address: _____Driver's License # _____
Confirm Appointments to: Home □ Cell □ Work □ Email □ Text Message □
Employer's Name and Address: _____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency: _____
If patient is a minor, please print Guardian's name: _____
If patient is a student, please print school name and location: _____
_____

PERSON RESPONSIBLE for THIS ACCOUNT

If same as above, check here □
Name: _____Relation to Patient: _____
Address: _____Phone: _____
Date of Birth: _____Social Security Number: _____
Employer: _____ _Work Phone: _____

DENTAL INSURANCE INFORMATION

Insurance Co. Name: _____Group Number: _____
Name of Policyholder: _____Relation to Patient: _____
Ins Co. Address: _____City: _____State: _____ Zip: _____
Policyholder Date of Birth: _____ Social Security Number: _____ Phone: _____
Employer: _____Do you have an Insurance Card? No □ Yes □
If YES, please show card to front desk.

Do You Have a Second Dental Insurance? No □ Yes □ If Yes, Please List
Insurance Co. Name: _____Group Number: _____
Name of Policyholder: _____Relation to Patient: _____
Ins Co. Address: _____City: _____State: _____ Zip: _____
Policyholder Date of Birth: _____ Social Security Number: _____ Phone: _____
Employer: _____Do you have an Insurance Card? No □ Yes □

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Springwood Dental all insurance benefits. I authorize the use of my signature on all insurance submissions whether manual or electronic.

Signature _____Date _____Relationship to Patient _____

Many of our patients are covered by dental insurance. Due to the extreme variations in insurance policy coverage, we encourage our patients to check with their insurance company or employer to determine their specific coverage. This includes the participating provider list and out-of-network payment schedule.

Please Proceed to the Next Page

HEALTH HISTORY

Physician's Name: _____Office Phone: _____
Previous Dentist and Location: _____Date of Last Visit: _____
Have you had Radiographs within the Past Year? Yes □ No □ If YES, Bitewings □ Panorex □ Full Mouth □

	Yes	No
Are you currently under medical treatment?	□	□
If yes, please explain _____		
Have you been hospitalized within last 5 years?	□	□
If yes, please explain _____		
Are you taking any prescription drugs?	□	□
If yes, please list _____		
_____		
Are you taking any over the counter drugs or Herbal/natural supplements?	□	□
If yes, please list _____		
Do you take Blood Thinners? (Coumadin, Plavix, Asprin, Warfarin, etc)	□	□
Do you take any Bone Density medications? (Zometa, Fosamax, etc)	□	□
Do you need antibiotic premedication before dental visits?	□	□
If yes, Why? _____		
Do you use tobacco?	□	□
If yes, what type? Cigarettes □ Chew □ Pipe □		

Do you have or have had any of the following?

	Yes	*No*		*Yes*	*No*
High Blood Pressure	□	□	***Hepatitis A□ B□ C□***	□	□
Heart Attack/Stroke	□	□	***Tuberculosis***	□	□
Prosthetic Cardiac Valve/Stint	□	□	***Thyroid Disease***	□	□
Bacterial Endocarditis	□	□	***Radiation Treatment***	□	□
Congenital Heart Disease	□	□	***Cancer/Chemotherapy***	□	□
Prosthetic Joint Replacement	□	□	***Liver Disease***	□	□
Cardiac Transplant	□	□	***Kidney Disease***	□	□
Diabetes Type 1 Type II	□	□	***Epilepsy/Seizures***	□	□
Cardiac Pacemaker	□	□	***Prolonged Bleeding***	□	□
HIV/AIDS	□	□	***Fainting Tendency***	□	□
Dry Mouth	□	□	***Gags easily***	□	□
Clenching/grinding teeth	□	□	***Other _____***		

Allergy to or have had a bad reaction to any of the following:

	Yes	*No*		*Yes*	*No*
Latex rubber	□	□	***Any other Antibiotics***	□	□
Dental Anesthetics	□	□	***Codeine***	□	□
Sulfa Drugs	□	□	***Metals/Jewelry***	□	□
Penicillin	□	□	***Other _____***		

Women Only, Are You:	Yes	No
Pregnant?	□	□
Nursing?	□	□
Taking Birth Control or Hormonal replacement	□	□

Is there anything else we should know about your medical history? _____
Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

Welcome

Our goal is to help you reach and maintain Maximum dental health. **Please fill out these forms completely.** The better we communicate, the better we can care for you.

Springwood Dental Associates