Aspen Grove Dental Associates

First Visit Form

Patient

Today's Date: _____/_____/_____ File #: _____

Patient Name: _____ What You Prefer To Be Called: _____
LAST FIRST MI

Birthdate: _____/_____/_____ Age: _____ SS#: _____-_____-_____

Mailing Address: _____
STREET CITY STATE ZIP

Home Phone #: _____ Work Phone #: _____ Other Phone #: _____

E-mail Address: _____ Referred by: _____

Employer: _____ How Long? _____ Occupation: _____

Employer's Address: _____

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: _____ Do You Have Children? ☐ Yes ☐ No If yes, how many? _____

Emergency

Who should we contact? _____ Relation: _____

Home Phone #: _____ Work Phone #: _____

Who is your Primary Care Physician? _____ Physician's Phone #: _____

Account Holder

Person ultimately responsible for account

Name: _____ Relation: _____ SS#: _____-_____-_____

Billing Address: _____
STREET CITY STATE ZIP

Driver's License #: _____ Work Phone #: _____

Payment Method: ☐ Cash ☐ Check ☐ Credit Card # _____

_____ *I hereby authorize assignment of my insurance, rights, and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office.)*
INITIALS

Insurance

Primary Dental Insurance Co. Name: _____ Group # _____ ID # _____

Mailing Address: _____
STREET CITY STATE ZIP

Phone #: _____ Insured's SS#: _____ DOB: _____/_____/_____

Insured's Name: _____ Relation: _____ Employer: _____

Secondary Dental Insurance Co. Name: _____ Group # _____ ID # _____

Mailing Address: _____
STREET CITY STATE ZIP

Phone #: _____ Insured's SS#: _____ DOB: _____/_____/_____

Insured's Name: _____ Relation: _____ Employer: _____

Aspen Grove Dental Associates

Dental Information

Reason for appointment: ☐ Exam ☐ Emergency ☐ Consultation Are you in pain? ☐ No ☐ Yes How Long? _____
Please indicate the following problems:

☐ Discomfort, clicking, or popping in jaw
☐ Red, swollen or bleeding gums
☐ Sensitive tooth, teeth, or gums
☐ Blisters/sores in or around the mouth
☐ Lost/Broken Filling(s)
☐ Teeth grinding
☐ Ringing in ears
☐ Broken/chipped tooth
☐ Stained Teeth
☐ Bad breath
☐ Locking Jaw

☐ Other: _____

Do you require pre-medications? ☐ Yes ☐ No ☐ Don't know
Previous Dentist: _____ Phone #: _____
Last Dental Exam? _____/_____/_____ Last Dental X-rays? _____/_____/_____

Times a day you brush? _____ Times a week you floss? _____

What type of toothbrush bristles do you use? ☐ Soft ☐ Medium ☐ Hard

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

Medical History

What medications are you taking?

☐ Nerve pills ☐ Pain killers (including aspirin) ☐ Muscle relaxers ☐ Stimulants
☐ Blood thinners ☐ Tranquilizers ☐ Insulin ☐ Meds for Osteoporosis
☐ Other(s), please list: _____

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

☐ Heart Attack/Stroke	☐ Thyroid Problems	☐ Cancer/Tumors	☐ Cosmetic Surgery
☐ Heart Surg./Pacemaker	☐ Kidney Problems	☐ Shingles	☐ X-ray/Cobalt Treatment
☐ Heart Murmur	☐ Liver Problems	☐ Hepatitis	☐ Chemotherapy
☐ Rheumatic Fever	☐ Respiratory Problems	☐ HIV+/AIDS/ARC	☐ Asthma
☐ Mitral Valve Prolapse	☐ Sinus Problems	☐ Arthritis/Rheumatism	☐ Difficulty Breathing
☐ Artificial Valves	☐ Stomach Problems/Ulcers	☐ Artificial Bones/Joints	☐ Diabetes/Hypoglycemia
☐ Heart Disease	☐ Psychiatric Problems	☐ Emphysema	☐ Leukemia
☐ Congenital Heart Defect	☐ Venereal Disease	☐ Fainting/Seizures/Epilepsy	☐ Anemia
☐ Chest Pains	☐ Alcohol/Drug Abuse	☐ Severe/Frequent Headaches	☐ High/Low Blood Pressure
☐ Scarlet Fever	☐ Tuberculosis TB	☐ Frequent Neck Pain	☐ Bleeding Problems
☐ Nervousness	☐ Jaw Problems TMJ/TMD	☐ Back Problems	☐ Glaucoma

☐ Please list any other surgeries or medical conditions you have or ever had:
_____

Are you allergic to any of the following? ☐ Latex ☐ Penicillin/Amoxicillin ☐ Tetracycline ☐ Aspirin ☐ Dental Anesthetics
☐ Foods: _____ Others: _____
Do you use tobacco? ☐ No ☐ Yes/How used? _____ How much?_____ How long? _____
Please rate your health from 1-10: _____ Do you wear contact lenses? ☐ Yes ☐ No
Have you ever taken the drug Phen-ten or Redux? ☐ Yes ☐ No
For women: Are you taking birth control pills? ☐ Yes ☐ No How many children have you had? _____
Are you pregnant? ☐ Yes ☐ No If yes, how far along? _____ Are you nursing? ☐ Yes ☐ No

If you have any questions regarding our services, please ask.
Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collections agency fees, interest charges and any other expenses incurred in collecting your account.
I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____/____/_____

☐ ADULT PATIENT ☐ PARENT OR GUARDIAN ☐ SPOUSE

UPDATE
(office use only)
_____ __/__/__
INITIALS DATE
_____
COMMENTS
_____ __/__/__
INITIALS DATE
_____
COMMENTS
_____ __/__/__
INITIALS DATE
_____
COMMENTS