Earnest Trent, D.D.S.
General and Implant Dentistry

Thank you for selecting our dental office! We strive to provide you with the best possible dental care. To help us meet your dental health care needs, please fill out this form. If you have questions, please ask us and we will be happy to assist you.

Patient Information

Name (first, middle initial, last): _____ Today's date: _____
Do you go by another name?_____ SSN: _____ DOB: _____
Address: _____ City: _____ State: _____ Zip: _____
Email: _____ Home phone: _____ Cell phone: _____
Would you prefer a confirmation call or text message the day before yours appointments? ☐ Call ☐ Text
Check the appropriate one: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed
Name of employer: _____
Employer address (city, state): _____ Work phone: _____
Do you have dental insurance? ☐Yes ☐No
For your convenience, we offer the following methods of payment. Please check the option(s) you prefer.
☐Cash ☐Check ☐Card ☐Care Credit ☐I would like more information about Care Credit financing.
How did you hear about our office? _____
Person to contact in case of emergency: _____ Phone: _____

Responsible Party

If the patient is the only person responsible for this account, you can leave this section blank.

Person responsible for this account: _____ Relationship to patient: _____
Is this person currently a patient at our office? ☐ No ☐ Yes *If yes, you can leave the rest of this section blank.*
Address: _____ City: _____ State: _____ Zip: _____
Email: _____ Home phone: _____ Cell phone: _____
Name of employer: _____ SSN: _____ DOB: _____
Employer address (city, state): _____ Work phone: _____

Insurance Information

If you have your insurance card with you, you do not need to fill out this section.

Name of insured: _____ Relationship to patient: _____ DOB: _____
SSN: _____ Employer: _____ Union/Local #: _____
Employer address (city, state): _____ Work phone: _____
Insurance company: _____ Group #: _____ Policy/ID #: _____
Ins. co. address: _____ City: _____ State: _____ Zip: _____

Do you have additional insurance? ☐No ☐Yes *If yes, please fill out the next section.*
Name of insured: _____ Relationship to patient: _____ DOB: _____
SSN: _____ Employer: _____ Union/Local #: _____
Employer address (city, state): _____ Work phone: _____
Insurance company: _____ Group #: _____ Policy/ID #: _____
Ins. co. address: _____ City: _____ State: _____ Zip: _____

Please fill out the back of this form.

Patient Medical History

Physician: _____ Office phone: _____ Date of last exam: _____

	Yes	No
1 Are you under any medical treatment now?	☐	☐
2 Have you been hospitalized for any surgical operation or serious illness in the last five years? If yes, please explain. _____ _____ _____	☐	☐
3 Are you taking any medications, including non-prescription medicine? If yes, please list. _____ _____ _____	☐	☐
4 Have you ever taken Fen-Phen/Redux?	☐	☐
5 Have you ever taken Fosamax, Boniva, Actonel, or any cancer medications containing bisphosphonates?	☐	☐
6 Have you taken Viagra, Revatio, Cialis, or Levitra in the last 24 hours?	☐	☐
7 Do you use tobacco?	☐	☐
8 Do you use controlled substances?	☐	☐

	Yes	No
10 Are you wearing contact lenses?	☐	☐
11 Are you allergic or have you had reactions to the following?		
Local anesthetics (e.g. Novacain)	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbituates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any metals (e.g. nickel, mercury, etc.)	☐	☐
Latex rubber	☐	☐
Other (Please list.) _____	☐	☐
12 Do you have a persistent cough or throat clearing not associated with an illness, lasting more than three weeks?	☐	☐
13 Women only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

9 Do you have or have you had any of the following? (Check all that apply.)

	Yes	No		Yes	No		Yes	No
High blood pressure	☐	☐	Heart disease	☐	☐	Chest pains	☐	☐
Heart attack	☐	☐	Cardiac pacemaker	☐	☐	Easily winded	☐	☐
Rheumatic fever	☐	☐	Heart murmur	☐	☐	Stroke	☐	☐
Swollen ankles	☐	☐	Angina	☐	☐	Hay fever / allergies	☐	☐
Fainting / seizures	☐	☐	Frequently tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation therapy	☐	☐
Low blood pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / convulsions	☐	☐	Cancer	☐	☐	Recent weight loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver disease	☐	☐
Diabetes	☐	☐	Joint replacement / implant	☐	☐	Heart trouble	☐	☐
Kidney disease	☐	☐	Hepatitis / jaundice	☐	☐	Respiratory problems	☐	☐
AIDS or HIV	☐	☐	Sexually transmitted disease	☐	☐	Mitral valve prolapse	☐	☐
Thyroid problem	☐	☐	Stomach troubles / ulcers	☐	☐	Other: _____	☐	☐

Please be sure to answer 10-13 in the upper right hand corner of the form.

Patient Dental History

Name of previous dentist: _____ Location: _____ Date of last exam: _____

	Yes	No
1 Do your gums bleed while brushing or flossing?	☐	☐
2 Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3 Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4 Do you feel pain to any of your teeth?	☐	☐
5 Do you have any sores or lumps in or near your mouth?	☐	☐
6 Have you had any head, neck, or jaw injuries?	☐	☐
7 Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8 Do you have frequent headaches?	☐	☐
9 Do you clench or grind your teeth?	☐	☐
10 Do you bite your lips or cheeks frequently?	☐	☐
11 Have you had any difficult extractions in the past?	☐	☐
12 Have you ever had any prolonged bleeding following an extraction?	☐	☐
13 Have you had any orthodontic treatment?	☐	☐
14 Do you wear dentures or partials?	☐	☐
15 Have you ever received oral hygeine instructions regarding the care and teeth of your gums?	☐	☐

Please be sure to answer 10-13 in the upper right hand corner of the form.

Authorization and Relase

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to relase any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carriers may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent/guardian if minor) *Date*

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General and Implant Dentistry

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Patient Responsibility Form

I agree that all charges incurred in this office are the sole responsibility of myself and/or my spouse in the event that my insurance company does not cover all costs. These costs would include co-payments, deductibles, and balances remaining after payment of the insurance company (if not self-paying patient). If these charges are not paid within a reasonable amount of time, I am aware that there may be interest on the unpaid balance or possible collection activity. Furthermore, in the event that court proceedings, and therefore court costs, are necessary in order for this office to collect any balance due, myself and/or my spouse are responsible for said costs associated with the court proceedings. Costs include, but are not limited to: filing fees, attorney's fees, witness fees, etc. The court costs are in addition to any balance due.

_____
Print Patient Name

_____
Patient or Guardian Signature

_____
Date