DR. JERRY S. ALVIS, D.D.S. PA

NEW PATIENT

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ABOUT YOU

Today's Date: _____ File #:_____

Patient Name:_____
Last First MI

What you prefer to be called: _____ ☐ Male ☐ Female

Birthday: _____ Age: _____ SSN:_____

Mailing Address:_____

City: _____ State: _____ Zip: _____

Home Phone #:_____

Work Phone #: _____ Ext:_____

Cell Phone #:_____

E-mail Address:_____

Referred By:_____

Employer:_____ How long? ____

Employer's Address:_____

City: _____ State: _____ Zip: _____

Occupation: _____

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

Spouse's Name:_____
Last First MI

Birthday: _____ Age: _____ SSN:_____

Do you have children? ☐ Yes ☐ No How many? _____

ACCOUNT INFORMATION

Person Ultimately Responsible for Account

Name: _____
Last First MI

Relation: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

SSN: _____

Driver's License #: _____

Work Phone #:_____ Ext: _____

_____ 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 INFORMATION

Primary Dental Insurance

Co. Name: _____

Mailing Address:_____

City: _____ State: _____ Zip: _____

Phone #:_____

Insured's ID #:_____

Group # (Plan, Local or Policy #):_____

Insured's Name:_____
Last First MI

Relation: _____ DOB:_____

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Mailing Address:_____

City: _____ State: _____ Zip: _____

Phone #:_____

Insured's ID #:_____

Group # (Plan, Local or Policy #):_____

Insured's Name:_____
Last First MI

Relation: _____ DOB:_____

Insured's Employer: _____

IN EVENT OF AN EMERGENCY

Whom Should We Contact?

Name: _____
Last First MI

Relation: _____

Home Phone #: _____

Work Phone #:_____ Ext: _____

Cell Phone #:_____

Who is your medical doctor? _____

Medical Doctor's Phone #: _____

(1 of 2) continued

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: _____

_____

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax): ☐ Yes ☐ No
Phen-fen/Redux: ☐ Yes ☐ No

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

Y	N		Y	N	
☐	☐	Heart Attack/Stoke	☐	☐	Cancer/Tumors
☐	☐	Heart Surgery/Pacemaker	☐	☐	Shingles
☐	☐	Heart Murmur	☐	☐	Hepatitis
☐	☐	Rheumatic Fever	☐	☐	HIV+/AIDS/ARC
☐	☐	Mitral Valve Prolapse	☐	☐	Arthritis/Rheumatism
☐	☐	Artifical Valves	☐	☐	Artifical Bones/Joints
☐	☐	Heart Disease	☐	☐	Emphysema
☐	☐	Congenital Heart Defect	☐	☐	Fainting/Seizures/Epilepsy
☐	☐	Chest Pains	☐	☐	Severe/Frequent Headaches
☐	☐	Scarlet Fever	☐	☐	Frequent Neck Pain
☐	☐	Nervousness	☐	☐	Back Problems
☐	☐	Thyroid Problems	☐	☐	Cosmetic Surgery
☐	☐	Kidney Problems	☐	☐	X-ray or Cobalt Treatment
☐	☐	Liver Problems	☐	☐	Chemotherapy
☐	☐	Respiratory Problems	☐	☐	Asthma
☐	☐	Sinus Problems	☐	☐	Difficulty Breathing
☐	☐	Stomach Problems/Ulcers	☐	☐	Diabetes/Hypoglycemia
☐	☐	Psychiatric Problems	☐	☐	Leukemia
☐	☐	Veneral Disease	☐	☐	Anemia
☐	☐	Alcohol/Drug Abuse	☐	☐	High/LowBlood Pressure
☐	☐	Tuberculosis (TB)	☐	☐	Bleeding Problems
☐	☐	Jaw Problems (TMJ/TMD)	☐	☐	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: _____
☐ Other: _____

Do you use tobacco? ☐ Yes ☐ No
If yes, How Used? _____
How Much: _____ How Long: _____

Do you drink and of the following? ☐ Soda ☐ Alcohol ☐ Coffee ☐ Tea

Please rate your general health from 1-10: _____

Do you wear contact lenses? ☐ 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? _____

Are you nursing? ☐ Yes ☐ No

DENTAL INFORMATION

What is the reason for today's visit?

☐ Exam ☐ Emergency ☐ Consultation

Are you in pain? ☐ Yes ☐ No If yes, How long? _____

Please indicate any of the following problems?

Y	N	
☐	☐	Discomfort, Clicking or Popping Jaw
☐	☐	Red, Swollen or Bleeding Gums
☐	☐	Sensitive Tooth, Teeth or Gums
☐	☐	Blister/Sores In or Around the Mouth
☐	☐	Lost/Broken Fillings
☐	☐	Teeth Grinding
☐	☐	Ringing In Ears
☐	☐	Broken/Chipped Tooth
☐	☐	Stained Teeth
☐	☐	Locking Jaw
☐	☐	Bad Breath
☐	☐	Other: _____

Do you require pre-medication? ☐ Yes ☐ No ☐ Don't know

Previous dentist: _____

Previous dentist's Phone #: _____

Date of last dental exam: _____

Date of last dental X-ray: _____

How many times a day do you brush? _____

How many times a week do you floss? _____

What type of tooth brush 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)

We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly mutual understanding between provider and patient.

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, collection agency fees, interest charges and any other expense 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: ☐ Adult Parent ☐ Parent/Guardian ☐ Spouse Date

UPDATE (Office Use):

Initials	Date	Comment