Divine Dentistry

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Patient Information

Patient Name: _____ Date:_____
Last First MI

Patient Date of Birth_____ ☐ Male ☐ Female Patient's Social Security #: _____

Phone (Home): _____ (Work): _____ Ext:_____ Cell_____

Email address:_____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐Th ☐F

Address: _____
Street Apartment #

_____
City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? ☐ Another Dental Office ☐ Yellow Pages

☐ Newspaper ☐ School ☐ Work ☐ Another patient, friend/family ☐ Other_____

Name of person or office referring you to our practice:_____

Insurance Information

Primary

Name of Insured: _____
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____Phone Number:_____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐ Other_____

Insurance Company's Name, Address and Phone Number:_____

Secondary

Name of Insured: _____
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____Phone Number:_____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐ Other_____

Insurance Company's Name, Address and Phone Number:_____

Health and Dental Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ Allergies_____ _____
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Anemia
- ☐ Artificial Joints
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chemo-Active
- ☐ Diabetes-Type I or II
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/ AIDS
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mental Retardation
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy Due Date_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Seizures
- ☐ Sickle Cell Disease
- ☐ Sickle Cell Trait
- ☐ Sinus Problems
- ☐ Skin Disorder(s)
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Other_____

• Has the above mentioned patient ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain:_____

• Has the above mentioned patient been admitted to a hospital or needed emergency care during the past two years?

☐ Yes ☐ No If yes, please explain:_____

• Is the above mentioned patient now under the care of a physician? ☐ Yes ☐ No
If yes, please explain:_____

• Name of Physician: _____ Phone: _____

• Are there any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain:_____

• **Please list any medications you are currently taking:**

_____

●Is there anything else that you feel we should know about you or your child to help improve your dental treatment and personal relationship: _____

Please Take the Time to Check One.

There are **4 levels of care** we provide in our office. We believe that each individual has the right to become as healthy as they choose to be. Please choose which level best represents the way you wish to begin your relationship with us. **(It is not uncommon to begin at one level and progress to a higher level over time.)**

Level I - Emergency Care- Immediate Need_____
I am only interested in emergency dental care for the relief of pain and/or cosmetic embarrassment. I am not very interested in thinking about the future of my teeth at this time.

Level II – Maintenance/Preventative Care- Minimal Repair _____
I am interested in taking an active part in the prevention of the disease process and the repair of existing problem (example: regular cleanings, necessary fillings, etc.) . However, I am not yet ready for optimum care do to limitations of time and/or money. I understand maintenance dentistry may not be a long-term solution to my dental health.

Level III – Optimum/Functional Care - Ideal _____
I am interested in achieving and maintaining long-term optimum dental health with no limitations of time and/or money. I am concerned about treating the causes of dental disease, not simply the effects. I want all dental treatment provided to be the best option for maximum protection and longevity.

Level IV – Optimum/ Esthetic Care- Cosmetic____
I am interested in achieving and maintaining long-term optimum dental health with no limitations of time and/or money. I am concerned about treating the causes of dental disease, not simply the effects, but appearance is very important to me. I would like the ideal smile with no concern for cost.
If you could change anything about your smile, what would it be?