BAILEY & WRIGHT DENTISTRY

1035 North Post Road
Indianapolis, Indiana 46219
Phone: 317.897.6074
www.baileywrightdentistry.com

WELCOME

Thank you for selecting our dental healthcare team!

We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please call us and we will be happy to help 317.897.6074.

PATIENT INFORMATION (Confidential) Patient's Sex ___M ___F

Name _____ Birthday _____ Home Phone _____

Address _____ City _____ State _____ Zip Code _____

E-mail _____ Cell Phone _____

Do you prefer to receive calls at your: ___ Home ___ Work ___ Cell Phone

Check appropriate area: ___ Minor ___ Single ___ Married ___ Divorced ___ Widowed ___ Separated

If Student, Name of School/College _____ City _____ State _____ Full/Part Time _____

Patient or Parent Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip Code _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

Name of Person Responsible for this account _____ Relationship to Patient _____

Address _____ Home Phone _____

E-mail _____ Cell Phone _____

Driver's License # _____ Birthday _____ Financial Institution _____

Employer _____ Work Phone _____ SS #/SIN _____

Is this person currently a patient in our office? ___ Y ___ N

For your convenience, we offer the following methods of payment. Please check the option you prefer.
Payment is expected at time of service.

___ Cash ___ Personal Check ___ Credit Card Visa/MasterCard ___ I wish to discuss the office's payment policy

INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Birthday _____ SSN #/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip Code _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip Code _____

Insurance Company Phone Number _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ___ Y ___ N If yes, complete the following: _____

Name of Insured _____ Relationship to Patient _____

Birthday _____ SSN #/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip Code _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip Code _____

Insurance Company Phone Number _____

PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Date of Last Exam _____

1	Are you under medical treatment?	Y	N
2	Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	Y	N
3	Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	Y	N
4	Have you ever taken Fen-Phen/Redux?	Y	N
5	Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	Y	N
6	Have you taken Viagra, Revati, Cialis or Levitra in the last 24 hours?	Y	N
7	Do you use tobacoo?	Y	N
8	Do you use controlled substances?	Y	N
9	Do you have or have you had any of the following?	Y	N
10	Are you wearing contact lenses?	Y	N
11	Are you allergic to or have you had any reactions to the following?	Y	N
	Local Anesthetices (e.g. Novocaine)	Y	N
	Penicillin or any other Antibiotics	Y	N
	Sulfa Drugs	Y	N
	Barbiturates	Y	N
	Sedatives	Y	N
	Iodine	Y	N
	Aspirin	Y	N
	Any Metals (e.g. nickel, mercury, etc.)	Y	N
	Latex Rubber	Y	N
	Other	Y	N
12	Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	Y	N
13	Women Only:	Y	N
a	Are you pregnant or think you may be pregnant?	Y	N
b	Are you nursing?	Y	N
c	Are you taking oral contraceptives?	Y	N

14	High Blood Pressure	✔	Y		N
15	Heart Attack		Y		N
16	Rheumatic Fever		Y		N
17	Swollen Ankles		Y		N
18	Fainting / Seizures		Y		N
19	Asthma		Y		N
20	Low Blood Pressure		Y		N
21	Epilepsy / Convulsions		Y		N
22	Leukemia		Y		N
23	Diabetes		Y		N
24	Kidney Diseases		Y		N
25	AIDS or HIV Infection		Y		N
26	Thyroid Problem		Y		N
27	Heart Disease		Y		N
28	Cardiac Pacemaker		Y		N
29	Heart Murmur		Y		N
30	Angina		Y		N
31	Frequently Tired		Y		N
32	Anemia		Y		N
33	Emphysema		Y		N
34	Cancer		Y		N
35	Arthritis		Y		N
36	Joint Replacement or Implant		Y		N
37	Hepatitis / Jaundice		Y		N
38	Sexually Transmitted Disease		Y		N
39	Stomach Troubles / Ulcers		Y		N
40	Chest Pains		Y		N
41	Easily Winded		Y		N
42	Stroke		Y		N
43	Hay Fever / Allergies		Y		N
44	Tuberculosis		Y		N
45	Radiation Therapy		Y		N
46	Glaucoma		Y		N
47	Recent Weight Loss		Y		N
48	Liver Disease		Y		N
49	Heart Trouble		Y		N
50	Respiratory Problems		Y		N
51	Mitral Valve Prolapse		Y		N
52	Other _____		Y		N
	_____				
	_____				
	_____				

PATIENT DENTAL HISTORY

Name of Previous Dentist and Location _____

Do you have current x-rays? _____ Y N

Date of Last Exam _____

1	Do your gums bleed while brushing or flossing?	Y	N
2	Are your teeth sensitive to hot or cold liquids/foods?	Y	N
3	Are your teeth sensitive to sweet or sour liquids/foods?	Y	N
4	Do you feel pain to any of your teeth?	Y	N
5	Do you have any sores or lumps in or near your mouth?	Y	N
6	Have you had any head, neck, or jaw injuries?	Y	N
7	Have you ever experienced any of the following problems in your jaw?	Y	N
	Clicking	Y	N
	Pain (joint,ear, side of face)	Y	N
	Difficulty in opening or closing	Y	N
	Difficulty in chewing	Y	N
8	Do you have frequent headaches?	Y	N
9	Do you clench or grind your teeth?	Y	N
10	Do you bite your lips or cheeks frequently?	Y	N
11	Have you ever had any difficult extractions in the past?	Y	N
12	Have you ever had any prolonged bleeding following extractions?	Y	N
13	Have you had any orthodontic treatment?	Y	N
14	Do you wear dentures or partials?	Y	N
	If yes, date of placement. _____		
15	Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	Y	N
16	Do you like your smile?	Y	N

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AUTHORIZATION AND RELEASE

Payment is due in full at the time of treatment-unless prior arrangements have been approved.
This office accepts insurance. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductilbes that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Submit

X _____ _____

Signature of patient (or parent/guardian of minor) *Signature to be completed in person* Date