MONTGOMERY DENTAL CENTER

To speed up the check in process, please fill in ALL information

Do you receive services at any of our other sites? Please check all that apply:

☐ ***Sterling Health Care*** ☐ ***Sterling Women's Care*** ☐***Bath Family Health Services*** ☐***Nicholas Family Health Services***

How were you referred to Montgomery Dental Care? _____

Last Name: _____ **First Name**:_____ **Middle Name:** _____

Nickname:_____ **SSN:**_____ **Birth Date:**_____

Gender Identity:
□Male □Female □Transgender Male/Female to Male □Transgender Female/Male to Male □Other □Choose not to disclose

Sexual Orientation: □Straight □Lesbian or Gay □Bisexual □Don't Know □Choose not to disclose

Marital Status: □Divorced □Married □Separated □Single □Unknown □Widow

Race: □American Indian/Alaskan Native □Asian □Black/African American □Native Hawaiian □White □ Other
Ethnicity: □Hispanic/Latino □Non Hispanic/Non Latino

Preferred Language: □English □Spanish □Interpreter Needed

Mailing Address:_____ **Zip Code**:_____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email Address: _____ **Preferred Communication**: Phone/Email

Preferred Phone Contact: □Home □Cell □Work

Living Arrangements □ Alone □Family □Institution □Relative □Roommates □Spouse Only
Living Situation □ Homeless □Transitional □Doubling Up □Street □Other □Unknown □Not Homeless

Agricultural Worker □ Migrant □Seasonal **Are you a Veteran** □Yes □No

Who is your Primary Care Provider? _____

Are you pregnant? _____

Pharmacy: _____

In case of Emergency, please contact:

Name_____ **Phone:** _____ **Relation:**_____

Address_____

DENTAL INSURANCE INFORMATION:
Primary Insurance: _____ **ID#**_____ **GROUP#**_____
Secondary Insurance: _____ID#_____ GROUP#_____

Subscriber Name:_____ **Subscriber Date of Birth**_____

Subscriber Gender:____ **Subscriber Phone**_____

Subscriber Address if different from Patient:_____

Subscriber Employer:_____

EMPLOYMENT INFORMATION

□Full-time □Part-time □Unemployed □Full-time Student □Part-time Student
□Retired □Unknown □Active Military Duty

Employer Name: _____ **Employer Phone**:_____

Employer Address: _____

HOUSEHOLD INCOME INFORMATION

What is your annual household income? **How many people are in your household?** _____

□No income □Less than 24,999 □25,000 to 39,999 □40,000 to 59,999 □60,000 to 99,999 □100,000 or more

Are you seeking treatment that is related to a Worker Compensation or Auto Accident injury? □Yes □No

Are you pregnant? □Yes □No

MEDICAL INFORMATION

Please circle any of the following you are being treated for:

Blood Pressure: high or low	Heart Disease	Heart Valve
Rheumatic Fever	Asthma/COPD	Stroke
Hepatitis	Tuberculosis	Seizures
Immunocompromised Disease	Stomach Problems (ulcers, reflux, etc.)	Joint Replacement
Thyroid Problems	Kidney Disease	Back Problems
General Allergies	Pancreatitis	Sinus Problems
Diabetes	Bleeding Problems	Cancer/Radiation
Pacemaker	Headaches	Hemophilia
Other:		

ALLERGIES

FOR FEMALES ONLY

Are you pregnant or could you be? □Yes □No Date of last menstrual period_____

Are you currently using any type of birth control? □Yes □No If so, what kind? _____

Please list any medications you are currently taking or have taken in the past for *osteoporosis* (i.e. Boniva, Actonel, Fosamax)

_____

Please list your primary care doctor/provider and contact number:

Provider Name: _____ **Phone Number:** _____

Do you use tobacco? □Yes □No

If yes: How much and what type: _____ **How long have you used it:** _____

Do you use controlled substances (drugs) or have you used in the past? □Yes □No

Do you receive treatment at a pain clinic, either currently or in the past? □Yes □No

Please list ALL medications: (including over-the-counter medications)

Medication	Dosage/Strength	Frequency/Doses per day

DENTAL HISTORY

What is the reason for your dental visit today? **Exam** **Pain/swelling** **Broken tooth/filling**

How long has this been a problem or concern? _____

When was your last dental visit? _____

Reason for that visit: _____

Have you ever been shown how to brush and/or floss? ☐Yes ☐No

How many snacks do you eat per day (candy, pop, etc…)?

None **1 – 2 Per Day** **3 – 4 Per Day** **5 – 6 Per Day** **More than 4 per day**

The above information is accurate and complete, to the best of my knowledge, and is only for use in my treatment, billing and processing of insurance benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature _____ Date _____

Dentist's Signature _____ Date _____