

WELCOME!



Patient Information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ Date _____ SS# _____
First MI Last

Address _____ City _____ State _____ Zip _____

Birthdate _____ Home phone # _____ Work phone # _____

Do you prefer to receive calls at: Home Work Either Cell# _____

Are you: Minor Married Divorced Widowed Single Separated

Your or your parent's employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Spouse's or parent's name _____ Workplace _____ Work phone # _____

If you are a student, name of school/college _____ City _____ State _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone # _____

Responsible Party

Name of person responsible for this account? _____

Relationship to patient _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work phone # _____

Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date employed _____

Name of employer _____ Work phone # _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Employer # _____

DO YOU HAVE ADDITIONAL INSURANCE? No Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date employed _____

Name of employer _____ Work phone # _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

CONFIDENTIAL

Dental History

Name _____ Age _____

Former Dentist _____

Reason for today's visit _____

Date of last exam _____ Date of last dental X-rays _____

How often do you brush? _____ How often do you floss? _____

Please check any of the following conditions that apply to you:

- | | | |
|--------------------------------------------------------|---------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

Medical History

Physician _____ Date of last visit _____

Please list all medications you are currently taking: _____

Allergies: _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

- Do you have a history of the following?
- | | | | |
|--------------------------------------------------|-----------------------------------------------|------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pre-medicate |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemotherapy | Describe _____ | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Surgeries (last 2 yrs) | | | <input type="checkbox"/> Venereal Disease |

Authorization

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 release 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 payers and/or health practitioners. 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 carrier 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 if a minor)

DATE

