

Welcome!

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

Patient Information

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____
Last Name First Name Initial Home Phone _____

Address _____ Cell Phone _____

City _____ State _____ Zip _____ E-mail _____

Sex: M F Minor Single Married Long Term Partner Divorced Widowed Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Additional Insurance

Insured Name _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Dental History

Former Dentist _____

Date of Last X-Rays _____

City, State _____

How Often Do You Floss? _____

Date of Last Dental Visit _____

How Often Do You Brush? _____

Please check all that apply:

- Bad Breath
- Bleeding Gums
- Blisters on Lips or Mouth
- Finger Nail Biting
- Grinding Teeth
- Lip or Cheek Biting

- Loose Teeth or Broken Fillings
- Orthodontic Treatment
- Pain Around Ear
- Periodontal Treatment
- Sensitivity to Cold
- Sensitivity to Heat

- Sensitivity to Sweets
- Sensitivity When Biting
- Frequent Headaches
- Jaw, Head or Neck Injuries
- Jaw Difficulty: Clicking and/or Pain..
- Tooth Pain

Medical History

Physician's Name _____ Date of Last Visit _____

1. Are you currently under medical treatment? Yes No

2. Have you ever had any serious illnesses or operations? Yes No

3. Are you currently taking any medication? Yes No

Please describe: _____

4. Do you smoke? Yes No

5. Do you use alcohol, cocaine or other drugs? Yes No

6. Do you wear contact lenses? Yes No

Please check all that apply:

- AIDS
- Anemia.....
- Arthritis, Rheumatism
- Artificial Heart Valves
- Artificial Joints
- Asthma
- Back Problems
- Bleeding abnormally, with extractions or surgery
- Blood Disease
- Cancer
- Chemical Dependency
- Chemotherapy
- Chronic Fatigue Syndrome
- Circulatory Problems
- Congenital Heart Lesions.....
- Cortisone Treatments
- Cough - persistent or bloody....
- Diabetes.....

- Emphysema
- Epilepsy
- Fainting or Dizziness
- Glaucoma
- Headaches.....
- Heart Murmur
- Heart Problems.....
- Hepatitis-Type _____
- Herpes.....
- High Blood Pressure
- HIV Positive
- Jaundice
- Jaw Pain
- Kidney Disease
- Latex Sensitivity
- Liver Disease.....
- Low Blood Pressure
- Mitral Valve Prolapse.....
- Nervous Problems.....

7. Have you had any allergic reactions to the following:

- | | Yes | No |
|---|--------------------------|--------------------------|
| Local Anesthetics (eg. novocaine) | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin or other Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates (sleeping pills) | <input type="checkbox"/> | <input type="checkbox"/> |
| Sedatives | <input type="checkbox"/> | <input type="checkbox"/> |
| Iodine | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> |

8. (Women Only) Are You:

- | | Yes | No |
|-----------------------------------|--------------------------|--------------------------|
| Pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| Nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| Taking birth control pills? | <input type="checkbox"/> | <input type="checkbox"/> |

- Pacemaker.....
- Psychiatric Care
- Radiation Treatment.....
- Respiratory Disease.....
- Rheumatic Fever
- Scarlet Fever
- Shortness of Breath
- Sinus Trouble.....
- Skin Rash
- Stroke
- Swelling of Feet/Ankles.....
- Swollen Neck Glands.....
- Thyroid Problems.....
- Tonsillitis
- Tuberculosis.....
- Tumor or growth on head/neck.....
- Ulcer.....
- Venereal Disease

Assignment and Release

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____