Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date _____ Birthdate _____ Cell Phone _____ Home Phone _____

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address_____ Business Phone _____

Whom may we thank for referring you?_____

In case of emergency, who should be notified?_____ Phone _____

Primary Dental Insurance

Personal Responsible for Account _____
Last Name First Name Initial

Relation to Patient_____ Birthdate _____ Soc. Sec. # _____

Address (if different than patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Additional Dental Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different than patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Please complete both sides.

Dental History

Reason for Today's Visit _____

Date of Last Dental Visit _____ Date of Last Teeth Cleaning _____

Previous Dentist _____ Reason for Changing Dentist _____

Check if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Pain or swelling in head or neck
- ☐ Periodontal treatment
- ☐ Sensitivity to hot or cold
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

Are you satisfied with the appearance and color of your teeth? ☐ Yes ☐ No

Medical History

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

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

Check if you have or have had any of the following:

- ☐ AIDS
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Thinner
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Headaches (Frequent)
- ☐ Heart Murmur
- ☐ Heart Problems
  Describe_____
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Shortness of Breath
- ☐ Stroke
- ☐ Swelling of Feet/Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ **NONE**

MEDICATIONS

List medications you are currently taking _____

_____

ALLERGIES

☐ Aspirin ☐ Barbiturates (Sleeping pills) ☐ Codeine ☐ Iodine ☐ Latex ☐ Local Anesthetic ☐ Penicillin ☐ Sulfa ☐ **NONE**

☐ Other_____

Authorization

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.