

WELCOME TO OUR PRACTICE!



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 _____ Home Phone _____
Last Name First Name Initial
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 DENTAL 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 # _____

Please complete reverse side

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..... <input type="checkbox"/> | Loose Teeth or Broken Fillings..... <input type="checkbox"/> | Sensitivity to Sweets <input type="checkbox"/> |
| Bleeding Gums <input type="checkbox"/> | Orthodontic Treatment <input type="checkbox"/> | Sensitivity When Biting <input type="checkbox"/> |
| Blisters on Lips or Mouth <input type="checkbox"/> | Pain Around Ear <input type="checkbox"/> | Frequent Headaches <input type="checkbox"/> |
| Finger Nail Biting <input type="checkbox"/> | Periodontal Treatment <input type="checkbox"/> | Jaw, Head or Neck Injuries <input type="checkbox"/> |
| Grinding Teeth <input type="checkbox"/> | Sensitivity to Cold <input type="checkbox"/> | Jaw Difficulty: Clicking and/or Pain..... <input type="checkbox"/> |
| Lip or Cheek Biting <input type="checkbox"/> | Sensitivity to Heat <input type="checkbox"/> | Tooth Pain <input type="checkbox"/> |

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| 1. Are you currently under medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had any serious illnesses or operations? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any medication? | <input type="checkbox"/> | <input type="checkbox"/> |

Please describe: _____

- | | | |
|--|--------------------------|--------------------------|
| 4. Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use alcohol, cocaine or other drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you wear contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |

Please check all that apply:

- | | | |
|---|--|--|
| AIDS <input type="checkbox"/> | Emphysema <input type="checkbox"/> | Pacemaker..... <input type="checkbox"/> |
| Anemia..... <input type="checkbox"/> | Epilepsy <input type="checkbox"/> | Psychiatric Care <input type="checkbox"/> |
| Arthritis, Rheumatism <input type="checkbox"/> | Fainting or Dizziness <input type="checkbox"/> | Radiation Treatment..... <input type="checkbox"/> |
| Artificial Heart Valves <input type="checkbox"/> | Glaucoma <input type="checkbox"/> | Respiratory Disease..... <input type="checkbox"/> |
| Artificial Joints <input type="checkbox"/> | Headaches..... <input type="checkbox"/> | Rheumatic Fever <input type="checkbox"/> |
| Asthma <input type="checkbox"/> | Heart Murmur <input type="checkbox"/> | Scarlet Fever <input type="checkbox"/> |
| Back Problems <input type="checkbox"/> | Heart Problems..... <input type="checkbox"/> | Shortness of Breath <input type="checkbox"/> |
| Bleeding abnormally, with extractions or surgery <input type="checkbox"/> | Hepatitis-Type _____ <input type="checkbox"/> | Sinus Trouble..... <input type="checkbox"/> |
| Blood Disease <input type="checkbox"/> | Herpes..... <input type="checkbox"/> | Skin Rash <input type="checkbox"/> |
| Cancer <input type="checkbox"/> | High Blood Pressure <input type="checkbox"/> | Stroke <input type="checkbox"/> |
| Chemical Dependency <input type="checkbox"/> | HIV Positive <input type="checkbox"/> | Swelling of Feet/Ankles..... <input type="checkbox"/> |
| Chemotherapy <input type="checkbox"/> | Jaundice <input type="checkbox"/> | Swollen Neck Glands..... <input type="checkbox"/> |
| Chronic Fatigue Syndrome <input type="checkbox"/> | Jaw Pain <input type="checkbox"/> | Thyroid Problems..... <input type="checkbox"/> |
| Circulatory Problems <input type="checkbox"/> | Latex Sensitivity <input type="checkbox"/> | Tonsillitis <input type="checkbox"/> |
| Congenital Heart Lesions..... <input type="checkbox"/> | Kidney Disease <input type="checkbox"/> | Tuberculosis..... <input type="checkbox"/> |
| Cortisone Treatments <input type="checkbox"/> | Liver Disease..... <input type="checkbox"/> | Tumor or growth on head/neck..... <input type="checkbox"/> |
| Cough - persistent or bloody..... <input type="checkbox"/> | Low Blood Pressure <input type="checkbox"/> | Ulcer..... <input type="checkbox"/> |
| Diabetes..... <input type="checkbox"/> | Mitral Valve Prolapse..... <input type="checkbox"/> | Venereal Disease <input type="checkbox"/> |
| | Nervous Problems..... <input type="checkbox"/> | |

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:

- | | | |
|-----------------------------------|--------------------------|--------------------------|
| Pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| Nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| Taking birth control pills? | <input type="checkbox"/> | <input type="checkbox"/> |

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 _____