

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 _____
Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____
Last Name First Name Initial
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 _____
Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____
Last Name First Name Initial
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.....
 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

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"/>

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
 Latex Sensitivity
 Kidney Disease
 Liver Disease.....
 Low Blood Pressure
 Mitral Valve Prolapse.....
 Nervous Problems.....

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 _____