

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 any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date _____ Home Phone _____
Name _____ Soc. Sec. # _____
Last First Initial
Address _____
City _____ State _____ Zip _____
Sex M F Age _____ Birthdate _____ 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 Insurance

Person Responsible for Account _____
Last First Initial
Relation to Patient _____ Birthdate _____ Soc. Sec. # _____
Address (If different from 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 Insurance

Is patient covered by additional insurance? Yes No
Subscriber Name _____ Relation to Patient _____ Birthdate _____
Address (If different from 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 _____
 Former Dentist _____
 Address _____
 Date of last dental care _____ Date of last dental X-rays _____
 Check (✓) if you have had problems with any of the following:
 Bad Breath Grinding Teeth Sensitivity to heat
 Bleeding Gums Loose teeth or broken fillings Sensitivity to sweets
 Clicking or popping jaw Periodontal treatment Sensitivity when biting
 Food collection between teeth Sensitivity to cold Sores or growths in your mouth

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

Medical History

Physicians Name _____ Date of Last Visit _____
 Have you had any serious illnesses or operations? Yes No If yes, describe _____
 Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____
 (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:

Y N	Y N	Y N	Y N
<input type="checkbox"/> <input type="checkbox"/> AIDS	<input type="checkbox"/> <input type="checkbox"/> Cortisone Treatments	<input type="checkbox"/> <input type="checkbox"/> Hepatitis	<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Cough, Persistent	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> <input type="checkbox"/> Arthritis, Rheumatism	<input type="checkbox"/> <input type="checkbox"/> Cough up Blood	<input type="checkbox"/> <input type="checkbox"/> HIV Positive	<input type="checkbox"/> <input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valves	<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Jaw Pain	<input type="checkbox"/> <input type="checkbox"/> Skin Rash
<input type="checkbox"/> <input type="checkbox"/> Artificial Joints	<input type="checkbox"/> <input type="checkbox"/> Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Kidney Disease	<input type="checkbox"/> <input type="checkbox"/> Stroke
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Fainting	<input type="checkbox"/> <input type="checkbox"/> Liver Disease	<input type="checkbox"/> <input type="checkbox"/> Swelling of Feet/Ankles
<input type="checkbox"/> <input type="checkbox"/> Back Problems	<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> <input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> <input type="checkbox"/> Blood Disease	<input type="checkbox"/> <input type="checkbox"/> Headaches	<input type="checkbox"/> <input type="checkbox"/> Nervous Problems	<input type="checkbox"/> <input type="checkbox"/> Tobacco Habit
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Heart Murmur	<input type="checkbox"/> <input type="checkbox"/> Pacemaker	<input type="checkbox"/> <input type="checkbox"/> Tonsillitis
<input type="checkbox"/> <input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> <input type="checkbox"/> Heart Problems	<input type="checkbox"/> <input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Chemotherapy	Describe _____	<input type="checkbox"/> <input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> <input type="checkbox"/> Ulcer
<input type="checkbox"/> <input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> <input type="checkbox"/> Hemophilia	<input type="checkbox"/> <input type="checkbox"/> Respiratory Disease	<input type="checkbox"/> <input type="checkbox"/> Venereal Disease

MEDICATIONS
 List Medications you are currently taking:

ALLERGIES

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.