

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 _____ 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 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 <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"/> | Would you like whiter teeth? <input type="checkbox"/> |

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 <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"/> | Kidney Disease <input type="checkbox"/> | Tonsillitis <input type="checkbox"/> |
| Congenital Heart Lesions..... <input type="checkbox"/> | Latex Sensitivity <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"/> | Osteoporosis medication <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:

- | | | |
|-----------------------------------|--------------------------|--------------------------|
| | 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"/> |

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 _____