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

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

Address _____

City _____ State _____ Zip _____ Phone _____

Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

E-Mail _____

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____ Work Phone _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc.Sec.# _____

Address (if different from patient) _____ Home Phone _____

City _____ Stale _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc.Sec.# _____

City _____ Stale _____ Zip _____ Phone _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Please complete both pages.

Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

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

❑ Bad breath
❑ Bleeding gums
❑ Clicking or popping jaw
❑ Food collection between teeth
❑ Grinding or clenching teeth
❑ Loose teeth or broken fillings
❑ Periodontal treatment
❑ Sensitivity to cold
❑ Sensitivity to hot
❑ Sensitivity to sweets
❑ Sensitivity when biting
❑ Sores or growths in mouth

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Other information about your dental health or previous treatment _____

Medical History

Physicians name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? ❑ Y ❑ N

If yes. describe _____

Are you currently under physician care? ❑ Y ❑ N If yes. describe

Have you ever had a blood transfusion? ❑ Y ❑ N If yes. give approximate dates _____

Women: Are you pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N

Check(✓) if you have had any or the following:

❑ AIDS/HIV Positive
❑ Anaphylaxis
❑ Anemia
❑ Arthritis. Rheumatism
❑ Artificial heart valves
❑ Artificial joints
❑ Asthma
❑ Atopic (allergy prone)
❑ Back problems
❑ Blood disease
❑ Cancer
❑ Chemical dependency
❑ Chemotherapy
❑ Circulatory problems
❑ Cortisone treatments
❑ Cough. persistent
❑ Cough up blood
❑ Diabetes
❑ Epilepsy
❑ Fainting
❑ Food allergies
❑ Glaucoma
❑ Headaches
❑ Heart murmur
❑ Heart problems
Describe _____
❑ Hemophilia/Abnormal bleeding
❑ Herpes
❑ Hepatitis
❑ High blood pressure
❑ Jaw pain
❑ Kidney disease or malfunction
❑ Liver disease
❑ Material allergies (latex, wool. metal. chemicals)
❑ Mitral valve prolapse
❑ Nervous problems
❑ Pacemaker/Heart surgery
❑ Psychiatric care
❑ Rapid weight gain or loss
❑ Radiation treatment
❑ Respiratory disease
❑ Rheumatic/Scarlet fever
❑ Shingles
❑ Short ness of breath
❑ Skin rash
❑ Spina Bifida
❑ Stroke
❑ Surgical implant
❑ Swelling of feet or ankles
❑ Thyroid disease or malfunction
❑ Tobacco habit
❑ Tonsillitis
❑ Tuberculosis
❑ Ulcer/Colitis
❑ Venereal disease
❑ Other

List medications you are currently taking. if any:

_____

_____

List drug allergies. if any:

_____

_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status. I will inform the dentist.

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 _____