Welcome!

Thank you for your visit today! We appreciate you trusting us to care for your dental health, and are pleased to welcome you to our practice. To help us serve you better, please take a few moments to fill out the following form as completely as you can. If you have any questions, just ask – we will be glad to help. We look forward to working with you!

Patient Information

Date _____ Home phone _____

Name _____ Social Security # _____

Address _____

City _____ State _____ Zip code _____

Sex ❑ Male ❑ Female Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

Occupation _____ Employed by _____

Business address _____ Work phone _____ Cell phone _____

Whom may we thank for referring you? _____

Whom may we notify in case of an emergency? _____ Phone _____

Primary Insurance

Who is responsible for this account?

Name _____

Relation to patient _____ Birthdate _____ Social Security # _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip code _____

Employed by _____ Occupation _____

Business address _____ Work phone _____

Insurance company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered by this plan _____

Secondary Insurance

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber name _____ Relation to patient _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip code _____

Subscriber employed by _____ Work phone _____

Insurance company _____ Social Security # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered by this plan _____

Please Complete Both Sides

Dental Health History

Reason for today's visit _____

Previous dentist _____ Address _____

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

Please check (✓) if you have had trouble with any of the following:

- ❑ Bad Breath
- ❑ Bleeding Gums
- ❑ Clicking or Popping Jaw
- ❑ Food collection between teeth
- ❑ Grinding Teeth
- ❑ Loose Teeth or Broken Fillings
- ❑ Periodontal Treatment
- ❑ Sensitivity to Cold
- ❑ Sensitivity to Heat
- ❑ Sensitivity to Sweets
- ❑ Sensitivity when Biting
- ❑ Sores or growths in your mouth

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

Medical History

Physician's name _____ Date of last visit _____

Previous hospitalizations, illnesses, or operations (please describe, and give approximate date) _____

Have you ever had a blood transfusion? ❑ Yes ❑ No If yes, please give approximate date _____

Any artificial implants? ❑ Yes ❑ No

Women: Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

Please check (✓) if you have or have had any of the following:

- ❑ AIDS
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Cortisone Treatments
- ❑ Cough, Persistent
- ❑ Cough up Blood
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart Problems

Describe _____

- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Jaw Pain
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mitral Valve Prolapse
- ❑ Nervous Problems
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Skin Rash
- ❑ Stroke
- ❑ Swelling of Feet or Ankles
- ❑ Thyroid Problems
- ❑ Tobacco Habit
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Venereal Disease

Please list any medications you are currently taking _____

Please list any allergies _____

Authorization

I have reviewed this questionnaire and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment, and I agree to notify the dentist if any change in my health status should occur.

I authorize the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize use of this signature on all insurance submissions.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.