WELCOME

Please take a few minutes to answer the following questions
so we can better assist you with your dental needs.

PATIENT INFORMATION

Date: _____ Social Security #: _____ - _____ - _____

Name: _____
Last Name First Name Initial

Home Phone: _____ Cell: _____

Address: _____

City _____ State _____ Zip _____

Email _____ Sex ☐ Male ☐ Female

☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Business Ph _____

Business Address _____ Occupation _____

Who would we thank for referring you? _____

In case of emergency, who should we contact? _____

Emergency Contact Phone Humber _____

PRIMARY INSURANCE

Person Responsible for Account

_____

Last Name First Name Initial

Relationship to Patient _____ Birthday _____

Social Security _____

Address _____

City _____ State _____ Zip _____

Responsible Party Employer _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D.#: _____ Group #: _____

ADDITIONAL INSURANCE

Insured Name _____

Last Name First Name Initial

Relationship to Patient _____ Birth date _____ SS#: _____

Address _____ City _____ State ____ Zip _____

Home Phone _____ Cell Phone _____

Insured Employed By _____Business Phone _____

Insurance Company Name and Address _____

Subscriber #: _____ Group #: _____

DENTAL HISTORY

Former Dentist _____ City, State, ZIP _____

Date of Last Dental Visit _____ Date of last X-Rays _____

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

PLEASE CHECK ALL THAT APPLY:

____ Bad Breath	____ Loose Teeth	____ Broker Fillings
____ Sensitivity to Sweets	____ Bleeding Gums	____ Finger Nail Biting
____ Blisters on Lips/Mouth	____ Grinding Teeth	____ Lip or Cheek Biting
____ Orthodontic Treatment	____ Pain around Ear	____ Periodontal Treatment
____ Sensitivity to Cold	____ Sensitivity to Heat	____ Tooth Pain
____ Sensitivity when biting	____ Frequent Headaches	
____ Jaw, Head of Neck Injuries	____ Jaw Difficulty, Clicking and/or Pain	

MEDICAL HISTORY

Physicians Name _____ Date of Last Visit _____

Are you currently under medical treatment? _____ Yes _____ No
Have you ever had any serious illnesses or operations? _____ Yes _____ No
Are you currently taking any medication? _____ Yes _____ No
Please Describe:

_____

_____

Do you smoke? _____ Yes _____ No
Do you use alcohol, cocaine or other drugs? _____ Yes _____ No
Do you wear Contact Lenses? _____ Yes _____ No

Have you had any allergic reactions to the following:	YES	NO
Local Anesthetics (eg. Novocain) …….	☐	☐
Penicillin or other Antibiotics ……	☐	☐
Sulfa Drugs …….	☐	☐
Barbiturates (sleeping pills) ……	☐	☐
Sedatives …….	☐	☐
Iodine …….	☐	☐
Aspirin ……	☐	☐
Other …….	☐	☐

(Women Only) Are You:

a. Pregnant? _____ Yes _____ No

b. Nursing? _____ Yes _____ No

c. Taking Birth Control Pills? _____ Yes _____ No

PLEASE CHECK ALL THAT APPLY:

_____ AIDS
_____ Anemia
_____ Arthritis, Rheumatism
_____ Artificial Heart Valves
_____ Artificial Joints
_____ Asthma
_____ Back Problems
_____ Bleeding Abnormally, with extractions or surgery
_____ Cancer
_____ Chemical Dependency
_____ Chemotherapy
_____ Chronic Fatigue Syndrome
_____ Circulatory Problems
_____ Congenital Heart Lesions
_____ Cortisone Treatments
_____ Cough – persistent or bloody
_____ Diabetes
_____ Emphysema
_____ Epilepsy
_____ Fainting/Dizziness
_____ Glaucoma
_____ Headaches
_____ Heart Murmur
_____ Hepatitis – Type __
_____ Herpes
_____ High Blood Presser
_____ Jaundice
_____ Kidney Disease
_____ Latex Sensitive
_____ Liver Disease
_____ Low Blood Pressure
_____ Mitral Valve Prolapse
_____ Nervous Problems
_____ Pacemaker
_____ Psychiatric Care
_____ Radiation Treatment
_____ Respiratory Disease
_____ Rheumatic Fever
_____ Scarlet Fever
_____ Sinus Trouble
_____ Skin Rash
_____ Stroke
_____ Swelling Feet/Ankles
_____ Swollen Neck Glands
_____ Tonsillitis
_____ Tuberculosis
_____ Ulcer
_____ Tumor/Growth head/neck
_____ 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