

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 _____

City, State _____

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 ☐
 Bleeding Gums ☐
 Blisters on Lips or Mouth ☐
 Finger Nail Biting ☐
 Grinding Teeth ☐
 Lip or Cheek Biting ☐

Loose Teeth or Broken Fillings ☐
 Orthodontic Treatment ☐
 Pain Around Ear ☐
 Periodontal Treatment ☐
 Sensitivity to Cold ☐
 Sensitivity to Heat ☐

Sensitivity to Sweets ☐
 Sensitivity When Biting ☐
 Frequent Headaches ☐
 Jaw, Head or Neck Injuries ☐
 Jaw Difficulty: Clicking and/or Pain.. ☐
 Tooth Pain ☐

Medical History

Physician's Name _____ Date of Last Visit _____

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Are you currently under medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had any serious illnesses or operations? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any medication? | <input type="checkbox"/> | <input type="checkbox"/> |

Please describe: _____

- | | | |
|--|--------------------------|--------------------------|
| 4. Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use alcohol, cocaine or other drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you wear contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |

Please check all that apply:

AIDS ☐
 Anemia..... ☐
 Arthritis, Rheumatism ☐
 Artificial Heart Valves ☐
 Artificial Joints ☐
 Asthma ☐
 Back Problems ☐
 Bleeding abnormally, with extractions or surgery ☐
 Blood Disease ☐
 Cancer ☐
 Chemical Dependency ☐
 Chemotherapy ☐
 Chronic Fatigue Syndrome ☐
 Circulatory Problems ☐
 Congenital Heart Lesions..... ☐
 Cortisone Treatments ☐
 Cough - persistent or bloody.... ☐
 Diabetes..... ☐

Emphysema ☐
 Epilepsy ☐
 Fainting or Dizziness ☐
 Glaucoma ☐
 Headaches..... ☐
 Heart Murmur ☐
 Heart Problems..... ☐
 Hepatitis-Type _____ ☐
 Herpes..... ☐
 High Blood Pressure ☐
 HIV Positive ☐
 Jaundice ☐
 Jaw Pain ☐
 Kidney Disease ☐
 Latex Sensitivity ☐
 Liver Disease..... ☐
 Low Blood Pressure ☐
 Mitral Valve Prolapse..... ☐
 Nervous Problems..... ☐

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:

Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>

Pacemaker..... ☐
 Psychiatric Care ☐
 Radiation Treatment..... ☐
 Respiratory Disease..... ☐
 Rheumatic Fever ☐
 Scarlet Fever ☐
 Shortness of Breath ☐
 Sinus Trouble..... ☐
 Skin Rash ☐
 Stroke ☐
 Swelling of Feet/Ankles..... ☐
 Swollen Neck Glands..... ☐
 Thyroid Problems..... ☐
 Tonsillitis ☐
 Tuberculosis..... ☐
 Tumor or growth on head/neck..... ☐
 Ulcer..... ☐
 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 _____