

WELCOME TO OUR PRACTICE!



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 DENTAL 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 # _____

Please complete reverse side

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 _____

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

7. Have you had any allergic reactions to the following:

	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Taking birth control pills?	<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 ☐
Latex Sensitivity ☐
Kidney Disease ☐
Liver Disease..... ☐
Low Blood Pressure ☐
Mitral Valve Prolapse..... ☐
Nervous Problems..... ☐

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 _____