WELCOME

Print Form

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 _____ _____ _____ Age _____ Date of Birth _____
Last Name *First Name* *Initial*

Address _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ E-mail _____

Spouse Name _____ Home Phone _____ Cell Phone _____

Please send me E-mail appointment reminders ☐ Yes ☐ No Add me to your E-mail Newsletter list ☐ Yes ☐ No

☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Business Phone _____

Whom may we thank for referring you? _____

Notify in case of emergency _____

Home Phone _____ Cell Phone _____

PRIMARY INSURANCE

Person Responsible for Account *(if different from patient)* _____ _____ _____
Last Name *First Name* *Initial*

Relation to Patient _____ Date of Birth _____ Soc. Sec. # _____

Address *(if different from patient)* _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Person responsible Employed by _____

Occupation _____ Business Phone _____

Insurance Company _____ Phone _____

Group # _____ Subscriber # _____

Name of other dependents under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Date of Birth _____

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

City _____ State _____ Zip _____ Home Phone _____ Cell Phone _____

Person responsible employed by _____

Occupation _____ Business Phone _____

Insurance Company _____ Phone _____

Group # _____ Subscriber # _____

Name of other dependents under this plan _____

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. 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.

Patient/Guardian Signature: _____ **Relationship:** _____ **Date** _____

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

DENTAL HISTORY

Name _____ _____ _____ Age _____ Date of Birth _____

Last Name *First Name* *Initial*

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

Former Dentist _____ Date of last dental 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? _____ How often do you 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? _____

Other information about your dental health or previous treatment _____

MEDICAL HISTORY

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? ☐ Yes ☐ No

If yes, describe _____

Are you currently under physician care? ☐ Yes ☐ No If yes, describe _____

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

Do you have, or had, any of the following?

- ☐ AIDS/HIV Positive
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial joints
- ☐ Asthma
- ☐ Back problems
- ☐ Blood disease
- ☐ Cancer
  - Type _____
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Cortisone treatments
- ☐ Cough, persistent
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart problems
  - Describe _____
- ☐ Hemophilia/Abnormal bleeding
- ☐ Herpes
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Kidney disease or malfunction
- ☐ Liver disease
- ☐ Material allergies (latex, wool, metal, chemicals)
- ☐ Nervous problems
- ☐ Pacemaker/Heart surgery
- ☐ Psychiatric care
- ☐ Rapid weight gain or loss
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Shingles
- ☐ Shortness of breath
- ☐ Skin rash
- ☐ Stroke
- ☐ Surgical implant
- ☐ Swelling of feet or ankles
- ☐ Thyroid disease or malfunction
- ☐ Tobacco habit
  - How much? _____
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer/Colitis
- ☐ Venereal disease
- ☐ Drink Alcohol
  - How much? _____
- ☐ Drug Abuse
  - Type? _____
- ☐ Other
  - Describe _____

Is patient currently taking any medications? If yes, list all:

_____

_____

Does patient have drug allergies? If yes, list all:

_____

_____

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 understand this information is confidential and will not be released without my signed consent.

Patient/Guardian Signature: _____ **Relationship:** _____

Date		Same		Intl		Changes	
Date		Same		Intl		Changes	
Date		Same		Intl		Changes	
Date		Same		Intl		Changes	