



Welcome

TO OUR
PRACTICE

*Thank you for trusting us with your dental care.
We promise to do our best to provide you with
the finest care available. If you have any
questions please do not hesitate to call us.*

Patient # _____

SS # _____

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years

E-mail _____ Alt. Phone #1 (____) _____ Alt. Phone #2 (____) _____

Employer/School _____ Employer/School Phone (____) _____

Employer/School Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone (____) _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone (____) _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone (____) _____

Driver's License # _____ Birthdate _____ Bank _____

Employer _____ Work Phone (____) _____

Currently a patient in our office? ☐ Yes ☐ No E-mail _____ Cell Phone (____) _____

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (____) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (____) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

- O V E R -

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____
Former Dentist _____ Date of last dental X-rays _____
Address _____

Check (✓) if you have had problems with any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between the teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> 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 _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

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

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- | Yes | No | Yes | No | Yes | No | Yes | No |
|--------------------------|--|--------------------------|---|--------------------------|--|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Anemia | <input type="checkbox"/> | <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> | <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> | <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> | <input type="checkbox"/> Artificial Joints, Pins, etc. | <input type="checkbox"/> | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> Asthma | <input type="checkbox"/> | <input type="checkbox"/> Diabetes | <input type="checkbox"/> | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> | <input type="checkbox"/> Back Problems | <input type="checkbox"/> | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> | <input type="checkbox"/> Bleeding Abnormally | <input type="checkbox"/> | <input type="checkbox"/> Fainting | <input type="checkbox"/> | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> | <input type="checkbox"/> Cancer | <input type="checkbox"/> | <input type="checkbox"/> Headaches | <input type="checkbox"/> | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> Rheumatic Fever | | |

List medications you are currently taking and the correlating diagnosis:

Allergies:

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

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