WELCOME

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*_____ _____ *Soc. Sec.#*_____
Last Name *First Name* *Initial*

*Address*_____ *Apt#*_____

*City*_____ *State* _____ *Zip Code*_____

*Cell*_____*Email*_____ *Home Phone* _____*Work Phone*_____

Sex □ *M* □ *F Age*_____ *Birthdate*_____ □ *Single* □ *Married* □ *Widowed* □ *Separated* □ *Divorced*

Patient Employed By _____*Occupation*_____

*Business Address*_____

Whom may we thank for referring you to our office? _____

*Notify in case of emergency*_____ *Home Phone*_____ *Cell*_____*work*_____

*Person responsible for Account*_____
Last Name *First Name* *Initial*
*Relation to patient*_____ *Birthdate* _____ *Soc. Sec. #*_____

*Address(If different from patient)*_____*Home Phone*_____ *Cell* _____*Work*_____

*City*_____ *State*_____*Zip Code*_____

*Email*_____

PRIMARY INSURANCE

Insured Name _____*Employers name*_____ *Soc. Sec.#*_____*DOB*_____

*Business Address*_____ *Business Phone*_____

*Insurance Company*_____*Insurance Phone*_____

*Group #*_____

Additional Insurance

Is Patient covered by additional insurance? □ *Yes* □ *No*

Subscriber Name _____*Relation to Patient*_____*Birthdate*_____ *Soc. Sec.#*_____

*Subscriber Employed by*_____ *Business Phone*_____

*Insurance Company*_____

*Phone*_____

Group # _____

Dental History

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

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?

Y/ N Bleeding gums	Y/ N Grinding or clenching teeth	Y/ N Sensitivity to cold/ hot
Y / N Bad breath	Y/ N Food collection between teeth	Y/ N Periodontal Treatment
Y / N Clicking or popping jaw	Y/ N Loose teeth or broken fillings	Y/ N Sensitivity to sweets
Y/ N Sensitivity when biting	Y /N Sores or growths in mouth	

How do you feel about the appearance of your teeth?_____

MEDICAL HISTORY

Physician's name_____
Date of last visit_____ Have you had any serious illnesses or operations Y/ N
If yes, describe_____
Are currently under physician care? Y/ N If yes, describe_____
Have you ever had a blood transfusion? Y/ N If yes, when_____
Have you ever taken Fen-Phen/ Redux? Y/ N

Women are you pregnant? Y/ N Nursing? Y/ N Taking birth control? Y/ N

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS?

Y/ N AIDS/HIV Positive	Y/ N Diabetes	Y/ N Kidney disease or malfunction	Y/ N Swelling of feet or ankles
Y/N Anemia	Y/ N Epilepsy	Y/ N Liver disease	Y/ N Thyroid disease or malfunction
Y/ N Arthritis, Rheumatism	Y/ N Fainting	Y/ N Mitral valve prolapse	Y/ N Tobacco habit
Y/ N Artificial joints	Y/ N Glaucoma	Y/ N Pacemaker/ Heart Surgery	Y/ N Tuberculosis
Y/ N Asthma	Y/ N Headaches	Y/ N Psychiatric care	Y/ N Ulcer/ Colitis
Y/ N Atopic (allergy prone)	Y/ N Heart murmur	Y/ N Rapid weight gain or loss	Y/ N Venereal disease
Y/ N Blood disease	Y/ N Heart problems	Y/ N Radiation treatment	
Y/ N Cancer	Y/ N Hemophilia/ Abnormal bleeding	Y/ N Respiratory disease	
Y/ N Chemical dependency		Y/ N Rheumatic/ Scarlet fever	
Y/ N Chemotherapy	Y/ N Hepatitis	Y/ N Shingles	
Y/ N Circulatory problems	Y/ N Herpes	Y/ N Shortness of breath	
Y/N Cough, persistent	Y/ N High blood pressure	Y/ N Stroke	
Y/N Cough up blood	Y/ N Jaw pain	Y/ N Surgical implant	

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

_____
_____

Does patient have allergies to drugs or medications ect:

_____
_____

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 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**.**

Signature_____ **Date** _____ **Dr. Initial**_____

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