

# 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

|   |   |                         |
|---|---|-------------------------|
| Date _____  | Phone (____) _____  | Alt. Phone (____) _____ |
| Name _____<br>Last Name First Name Middle Initial                                   | SS/HIC/Patient ID # _____   |                         |
| Address _____   | E-mail _____  |                         |
| City _____  | State _____   | Zip _____               |
| Sex <input type="checkbox"/> M <input type="checkbox"/> F Age _____ Birthdate _____ | <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Minor<br><input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered for _____ years |                         |
| Patient Employer/School _____   | Occupation _____  |                         |
| Employer/School Address _____   | Employer/School Phone (____) _____  |                         |
| Whom may we thank for referring you? _____  |   |                         |
| In case of emergency who should be notified? _____                                  |   | Phone (____) _____      |

## Primary Insurance

|   |   |  |
|---|---|--|
| Person Responsible for Account _____<br>Last Name First Name Middle Initial | Birthdate _____ ID#/Soc. Sec. # _____   |  |
| Relation to Patient _____   | Address (If different from patient's) _____<br>City _____ State _____ Zip _____ |  |
| Person Responsible Employed By _____  | Occupation _____  |  |
| Business Address _____  | Business Phone (____) _____   |  |
| Insurance Company _____   | Contract # _____ Group # _____ Subscriber # _____                               |  |
| Names of other dependents covered under this plan _____                     |   |  |

## Additional Insurance

|  |                             |                    |
|--|-----------------------------|--------------------|
| Is patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No |                             |                    |
| Subscriber Name _____  | Relation to Patient _____   | Birthdate _____    |
| Address (If different from patient's) _____  | Phone (____) _____          |                    |
| City _____   | State _____                 | Zip _____          |
| Subscriber Employed by _____   | Business Phone (____) _____ |                    |
| Insurance Company _____  | Soc. Sec. # _____           |                    |
| Contract # _____   | Group # _____               | Subscriber # _____ |
| Names of other dependents covered under this plan _____  |                             |                    |

Please Complete Both Sides





## 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 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

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

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Cough, Persistent    | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up Blood       | <input type="checkbox"/> HIV/AIDS              | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit              |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Ulcer                      |
| <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> Venereal Disease           |

MEDICATIONS: List medications you are currently taking: \_\_\_\_\_

ALLERGIES \_\_\_\_\_



## Authorization

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 my 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.**