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_____ Home Phone_____ Cell Phone_____

Email Address_____

Name_____ Preferred Name_____
Last Name First Name Initial

Address _____

City _____ State_____ Zip_____

Sex ☐ M ☐ F Age _____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation_____

Business Address _____ Business Phone_____

Whom may we thank for referring you? _____

In case of emergency who should be notified?_____ Phone_____

Primary Insurance

Person Responsible for Account _____ Soc. Sec. #_____
Last Name First Name Initial

Birthdate_____ Relationship to Patient_____

Address (If different from patient's) _____ Phone_____

City _____ State_____ Zip_____

Person Responsible Employed By _____ Occupation_____

Business Address _____ Business Phone_____

Insurance Company _____

Policy # or Group # _____ Member ID #_____

Names of other dependents covered under this plan _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ 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 _____

Former Dentist _____

Address _____

Date of last dental care _____ 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 teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ 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 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:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
  Describe _____
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Shortness of Breath
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Other
  Describe _____

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

ALLERGIES

_____

_____

_____

Authorization

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I understand that I am financially responsible for all charges whether or not paid by insurance. In the case of default of payment, I will pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account.

Signature _____ Date _____

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