

# 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 _____			
City _____	State _____	Zip _____	Home Phone _____
Cell Phone _____	Email _____		
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Age _____	Birthdate _____	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced
Patient Employed by _____		Occupation _____	
Business Address _____		Business Phone _____	
Business Email _____			
Whom may we thank for referring you? _____			
Notify in case of emergency _____	Home Phone _____		
Cell Phone _____	Business Phone _____		
Email _____			

## PRIMARY INSURANCE

Person Responsible for Account _____	Last Name _____	First Name _____	Initial _____
Relation to Patient _____	Birthdate _____	Soc. Sec. # _____	
Address (if different from patient) _____		Home Phone _____	
City _____	State _____	Zip _____	
Cell Phone _____	Email _____		
Person Responsible Employed by _____		Occupation _____	
Business Address _____		Business Phone _____	
Business Email _____			
Insurance Company _____	Phone _____		
Insurance Email _____			
Contract # _____	Group # _____	Subscriber # _____	
Name of other dependents 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) _____		Soc. Sec. # _____	
City _____	State _____	Zip _____	Home Phone _____
Cell Phone _____	Email _____		
Subscriber Employed by _____	Business Phone _____		
Business Email _____			
Insurance Company _____	Phone _____		
Insurance Email _____			
Contract # _____	Group # _____	Subscriber # _____	
Name of other dependents under this plan _____			

Please complete both sides.

## DENTAL HISTORY

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

Former Dentist \_\_\_\_\_ Address \_\_\_\_\_

Dentist's Email \_\_\_\_\_ Phone \_\_\_\_\_

Date of last dental care \_\_\_\_\_ Date of last x-rays \_\_\_\_\_

Check (✓) yes or no if you have had problems with any of the following:

<input type="checkbox"/> Y <input type="checkbox"/> N Bad breath	<input type="checkbox"/> Y <input type="checkbox"/> N Food collection between teeth	<input type="checkbox"/> Y <input type="checkbox"/> N Periodontal treatment	<input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets
<input type="checkbox"/> Y <input type="checkbox"/> N Bleeding gums	<input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching teeth	<input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to cold	<input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting
<input type="checkbox"/> Y <input type="checkbox"/> N Clicking or popping jaw	<input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth or broken fillings	<input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to hot	<input type="checkbox"/> Y <input type="checkbox"/> N Sores or growths in mouth

How often do you brush? \_\_\_\_\_ 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?  Y  N

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?  Y  N

If yes, describe \_\_\_\_\_

Are you currently under physician care?  Y  N If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Y  N If yes, give approximate dates: \_\_\_\_\_

Have you ever taken Fen-Phen/Redux?  Y  N

Women: Are you pregnant?  Y  N Nursing?  Y  N Taking birth control pills?  Y  N

Check (✓) yes or no whether you have had any of the following:

<input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive	<input type="checkbox"/> Y <input type="checkbox"/> N Cough, persistent	<input type="checkbox"/> Y <input type="checkbox"/> N Jaw pain	<input type="checkbox"/> Y <input type="checkbox"/> N Shingles
<input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis	<input type="checkbox"/> Y <input type="checkbox"/> N Cough up blood	<input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease or malfunction	<input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath
<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N Liver disease	<input type="checkbox"/> Y <input type="checkbox"/> N Skin rash
<input type="checkbox"/> Y <input type="checkbox"/> N Arthritis, Rheumatism	<input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N Material allergies (latex, wool, metal, chemicals)	<input type="checkbox"/> Y <input type="checkbox"/> N Spina Bifida
<input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves	<input type="checkbox"/> Y <input type="checkbox"/> N Fainting	<input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse	<input type="checkbox"/> Y <input type="checkbox"/> N Stroke
<input type="checkbox"/> Y <input type="checkbox"/> N Artificial joints	<input type="checkbox"/> Y <input type="checkbox"/> N Food allergies	<input type="checkbox"/> Y <input type="checkbox"/> N Nervous problems	<input type="checkbox"/> Y <input type="checkbox"/> N Surgical implant
<input type="checkbox"/> Y <input type="checkbox"/> N Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker/Heart surgery	<input type="checkbox"/> Y <input type="checkbox"/> N Swelling of feet or ankles
<input type="checkbox"/> Y <input type="checkbox"/> N Atopic (allergy prone)	<input type="checkbox"/> Y <input type="checkbox"/> N Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric care	<input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease or malfunction
<input type="checkbox"/> Y <input type="checkbox"/> N Back problems	<input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur	<input type="checkbox"/> Y <input type="checkbox"/> N Rapid weight gain or loss	<input type="checkbox"/> Y <input type="checkbox"/> N Tobacco habit
<input type="checkbox"/> Y <input type="checkbox"/> N Blood disease	<input type="checkbox"/> Y <input type="checkbox"/> N Heart problems	<input type="checkbox"/> Y <input type="checkbox"/> N Radiation treatment	<input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis
<input type="checkbox"/> Y <input type="checkbox"/> N Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N Describe _____	<input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease	<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis
<input type="checkbox"/> Y <input type="checkbox"/> N Chemical dependency	<input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/Abnormal bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet fever	<input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/Colitis
<input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N Herpes		<input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease
<input type="checkbox"/> Y <input type="checkbox"/> N Circulatory problems	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis		
<input type="checkbox"/> Y <input type="checkbox"/> N Cortisone treatments	<input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure		

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 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 \_\_\_\_\_