WELCOME

PATIENT INFORMATION

TODAY'S DATE____________________

Name______________________________ Nickname ______________ Birthdate ______________

Address ______________________________ City ______________________ State ________ Zip ______________

Home Phone ____________________ Cell Phone ____________________ S/M/F e-mail ______________________

Check Appropiate Box: ❒Minor ❒Single ❒Married ❒Divorced ❒Widowed ❒Separated

Patient's or Parent's Employer______________________ Work Phone __________________ Cell Phone ____________

Business Address__________________________ City______________________________ State ______ Zip ____________

Spouse or Parent's Employer______________________________________ Work Phone ______________

Business Address__________________________ City______________________________ State ______ Zip ____________

Best time and Place to reach you ____

If Patient is a Student, Name of School/College ____________________________ City____________________ State ______

Whom may we thank for referring you? ____

Person to contact in case of Emergency ____

Relationship________________________ Home Phone ____________________ Work 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

INSURANCE INFORMATION

Name of Insured ____ Relationship to Patient______________

Birthdate ______________________ Social Security #______________________ Date Employed ______________

Employer ____ Work Phone______________________

Employer Address ______________________________________ City ____________________State ____ Zip ____________

Insurance Co. ____________________ Phone # ______________ Group # ______________ Union or Local ____________

Business Address____________________________ City______________________________ State ______Zip ____________

How Much is your Deductible? ______________ How much have you used?______________ Max. Annual Benefit ______________

Do you have other coverage ❒Yes ❒No If yes, Name ____

DENTAL HISTORY

Reason for Todays Visit

____

____

Dentist Name______________________

City/ State ______________________

Date of Last Visit ______________________

Date of Last X-Ray ______________________

Place a mark on Yes or No to indicate if you have had any of the following:

Condition	Yes	No
Bad Breath	❒Yes	❒No
Bleeding Gums	❒Yes	❒No
Blisters on Lips or Mouth	❒Yes	❒No
Burning Sensation	❒Yes	❒No
Chew on one side of Mouth?	❒Yes	❒No
Cigarette, Pipe or Cigar Smoking	❒Yes	❒No
Clicking or Popping Jaw	❒Yes	❒No
Fingernail Biting	❒Yes	❒No
Food Collection Between Teeth?	❒Yes	❒No
Foreign Objects	❒Yes	❒No
Grinding Teeth	❒Yes	❒No
Gums Swollen or Tender	❒Yes	❒No
Jaw Pain or Tiredness	❒Yes	❒No
Lip or cheek biting	❒Yes	❒No
Loose Teeth or broken Fillings	❒Yes	❒No
Mouth Breathing	❒Yes	❒No
Mouth Pain, Brushing	❒Yes	❒No
Orthodontic Treatment	❒Yes	❒No
Pain arround Ear	❒Yes	❒No
Periodontal Treatment	❒Yes	❒No
Sensitivity to Cold/Hot	❒Yes	❒No
Pen/Pencil Chewing	❒Yes	❒No
Sensitivity to Sweets	❒Yes	❒No
Thumb Sucking	❒Yes	❒No
Sores or Growths in Your Mouth	❒Yes	❒No

How Often do you Floss? ______________

____

How Often do you Brush? ______________

____

HEALTH HISTORY

Physician's Name_______________ Date of Last Visit_______________

Place a mark on "Yes" or "No" to indicate if you have had any of the following

Condition	Yes	No
AIDS	❒Yes	❒No
Anemia	❒Yes	❒No
Arthritis, Rheumatism	❒Yes	❒No
Artificial Heart Valves	❒Yes	❒No
Artificial Joints	❒Yes	❒No
Asthma	❒Yes	❒No
Back problems	❒Yes	❒No
Bleeding abnormally, with Extractions or Surgery	❒Yes	❒No
Blood Disease	❒Yes	❒No
Cancer	❒Yes	❒No
Chemical dependency	❒Yes	❒No
Chemotherapy	❒Yes	❒No
Circulatory problems	❒Yes	❒No
Congenital Heart lesions	❒Yes	❒No
Cortisone treatments	❒Yes	❒No
Cough, persistent or bloody	❒Yes	❒No
Diabetes	❒Yes	❒No
Emphysema	❒Yes	❒No
Do you wear Contact Lenses	❒Yes	❒No
Epilepsy	❒Yes	❒No
Fainting or Dizziness	❒Yes	❒No
Glaucoma	❒Yes	❒No
Headaches	❒Yes	❒No
Heart Murmur	❒Yes	❒No
Heart problems	❒Yes	❒No
Hepatitis	❒Yes	❒No
Type_______________		
Herpes	❒Yes	❒No
High Blood pressure	❒Yes	❒No
HIV Positive	❒Yes	❒No
Jaundice	❒Yes	❒No
Jaw pain	❒Yes	❒No
Kidney disease	❒Yes	❒No
Liver disease	❒Yes	❒No
Low Blood pressure	❒Yes	❒No
Mitral Valve Prolapse	❒Yes	❒No
Nervous problems	❒Yes	❒No
Pacemaker	❒Yes	❒No
Women:		
Are you pregnant?	❒Yes	❒No
Due Date_______________		
Are you nursing?	❒Yes	❒No
Psychiatric Care	❒Yes	❒No
Radiation Treatment	❒Yes	❒No
Respiratory disease	❒Yes	❒No
Rheumatic Fever	❒Yes	❒No
Scarlet Fever	❒Yes	❒No
Shortness of Breath	❒Yes	❒No
Sinus trouble	❒Yes	❒No
Skin Rash	❒Yes	❒No
Special Diet	❒Yes	❒No
Stroke	❒Yes	❒No
Swelling of Feet or Ankles	❒Yes	❒No
Swollen Neck Glands	❒Yes	❒No
Thyroid problems	❒Yes	❒No
Tonsillitis	❒Yes	❒No
Tuberculosis	❒Yes	❒No
Tumor or Growth on head or neck	❒Yes	❒No
Ulcer	❒Yes	❒No
Venereal disease	❒Yes	❒No
Weight Loss, unexplained	❒Yes	❒No

MEDICATIONS

List medications you are currently taking:

____

____

____

Pharmacy Name:_______________

Phone _______________

ALLERGIES

- ❒ Aspirin
- ❒ Barbiturates (Sleeping Pills)
- ❒ Codeine
- ❒ Iodine
- ❒ Latex
- ❒ Nickel
- ❒ Local Anesthetic
- ❒ Penicillin
- ❒ Sulfa
- ❒ None
- ❒ Other_______________

____

UPDATES (to be filled in at future appointments)

Has there been any change in your health since your last dental appointment:

For what conditions? _______________

Are you taking any new medications? ___________ If so, what_______________

Patient Signature _______________ Date:_______________

Doctor Signature _______________ Date:_______________

Has there been any change in your health since your last dental appointment:

For what conditions?_______________

Are you taking any new medications? ___________ If so, what_______________

Patient Signature _______________ Date:_______________

Doctor Signature _______________ Date:_______________

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowlege. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benifits otherwise payable to me. I authorize the doctore 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. I authorize the use of this signiture on all insurance submissions.

Signature (Parent's signature, if minor) _______________ *Date* _______________

I understand that where appropriate, credit bureau reports may be obtained.

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