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 (___)_____
Name _____ Social Security # _____
Address _____ E-mail _____
City _____ State _____ Zip_____
Sex ☐ M ☐ F Age_____ Birthdate _____ ☐ Married ☐Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐Partnered for ____ years
Patient Employer / School _____ Occupation_____
Employer / School Address_____ Employer / School Phone (___)_____
Whom may we thank for referring you? _____
In Case of Emergency, Contact
Name _____Relationship _____
Home Phone (___)_____ Work Phone (___)_____

INSURANCE INFORMATION

Company Name _____
Address _____ City _____
State _____ Zip _____ Phone (___)_____
Insured's ID # _____ Group # (Plan, Local or Policy #) _____
Subscriber Name _____ Relation _____
Date of Birth _____

SECONDARY INSURANCE

Is Patient covered by additional insurance? ☐ Yes ☐ No
Subscriber Name _____ Relation to Patient_____ Birthdate_____
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:

☐ Bad Breath	☐ Grinding teeth	☐ Sensitivity to hot
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collection between teeth	☐ Sores or growths in your mouth	☐ Sensitivity to cold

How often do you floss?_____ How often do you brush? _____

HEALTH HISTORY

Physician's Name _____ Phone (___)_____

Place a (✓) on "yes" or "no" to indicate if you **HAVE** or **HAD** any of the following

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hepatitis Type _____	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Bleeding abnormally, with extractions/surgery	☐ Yes	☐ No	Heart Problems Describe _____	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
						Sleep Apnea	☐ Yes	☐ No
Blood disease	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Cough, persistent/bloody	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Tobacco Habit	☐ Yes	☐ No
			Radiation Treatment	☐ Yes	☐ No	Use of inhalers	☐ Yes	☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due Date _____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS	ALLERGIES	
List any medication you are currently taking and the correlation diagnosis:	☐ Aspirin	☐ Local Anesthetic
_____	☐ Codeine	☐ Penicillin/Amoxicillin
_____	☐ Iodine	☐ Sulfa
_____	☐ Latex	☐ Other _____
_____		_____

AUTHORIZATION

I have reviewed this questionnaire and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment, and I agree to notify the dentist if any changes in my health status should occur.

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

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

Signature _____ Date _____