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 ______ (Last Name / First Name / Middle Initial) SS/HIC/Patient ID # ______

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 who should be notified? ______ Phone (____) ______

Primary Insurance

Person Responsible for Account ______ (Last Name / First Name / Middle Initial)

Relation to Patient ______ Birthdate ______ Soc. Sec. # ______

Address (If different from patient's) ______ Phone (____) ______

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? ☐ Yes ☐ No

Subscriber Name ______ Birthdate ______ Relation to Patient ______

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 ______

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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
- ☐ 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 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:

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

MEDICATIONS

List medications you are currently taking:

____

____

ALLERGIES

____

____

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with ______________________ (Name of Insurance Company(ies)) and assign directly to 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.