

We are pleased to welcome you to our practice.

Thank you for taking the time to fill out this form prior to arrival. Please call us with any questions.



Patient Information:

Date: _____ Home Phone: _____
Name: _____ Social Security #: _____
Last Name First Name Middle Initial
Address: _____
City: _____ State: _____ Zip Code: _____
Sex: Male Female Age: _____ Birthdate: _____ Single Married Separated Divorced
Patient's Employer: _____ Occupation: _____
Business Address: _____ Business Phone: _____
Whom may we thank for referring you? _____
In case of emergency, who should be notified? _____ Phone: _____



Primary Insurance:

Responsible Party: _____ Relation to Patient: _____
Last Name First Name Middle Initial
Birthdate: _____ Social Security Number: _____
Address: (If different than patient's) _____
City: _____ State: _____ Zip Code: _____
Responsible Party's Employer: _____ Occupation: _____
Business Address: _____ Business Phone: _____
Insurance Company: _____ Contact Number: _____
Group Number: _____ Subscriber #: _____
Names of other dependants covered: _____



Additional/Secondary Insurance (if patient is covered):

Subscriber Name: _____ Relation to Patient: _____
Last Name First Name Middle Initial
Birthdate: _____ Social Security Number: _____
Address: (If different than patient's) _____
City: _____ State: _____ Zip Code: _____
Subscriber Employer: _____ Phone: _____
Insurance Company: _____ Contact Number: _____
Group Number: _____ Subscriber #: _____
Names of other dependants covered: _____



Dental History:

Reason for Today's Visit: _____

Former Dentist: _____

Address: _____

Date of last dental care: _____ Date of last dental x-rays: _____

Check (✓) if you had problems with any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to heat |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping teeth | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food Collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores/growths in your mouth |

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



Medical History:

Physician's Name: _____ Date of Last Visit: _____

Any Serious Illnesses or operations? Yes No If yes, describe: _____

Have you ever had a blood transfusion? Yes No If yes, give approx. date: _____

(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:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swelling of Feet/Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | Desc. _____ | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Venereal Disease |

Medications:

Allergies:

Please list medications you are currently taking:



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

Signature: _____

Date: _____