Welcome

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Date_____

PATIENT INFORMATION

Name_____ Birthdate_____ SS#_____

Home Phone_____ Cell Phone_____

Address_____ City_____ State_____ Zip_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or Parent's Employer_____ Work Phone_____

Business Address_____ City_____ State_____ Zip_____

Spouse or Parent's Name_____ Employer_____ Work Phone_____

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_____ Phone_____

CONTACT INFORMATION

How would you prefer our office to contact you to confirm your appointments?

_____ Home phone _____ Cell phone _____ Email phone _____ Text _____ Email & Text

Email address _____

INSURANCE INFORMATION

Name of Insured_____ Relation to Patient_____

Birthdate_____ Social Security #_____ Member ID# _____

Employer_____ Work Phone_____

Insurance Company_____ Group #_____ Union or Local #_____

ADDITIONAL INSURANCE

Name of Insured_____ Relation to Patient_____

Birthdate_____ Social Security #_____ Member ID# _____

Employer_____ Work Phone_____

Insurance Company_____ Group #_____ Union or Local #_____

OVER

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____

Date of last dental visit _____ Date of last dental X-rays _____

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

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Pain, clicking or popping jaw
- ☐ Food collection between the teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

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

Are you interested in: _____Snoring Appliance _____ Teeth Whitening _____ StraighterTeeth

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

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 had any of the following:

- ☐ Acid Reflex
- ☐ ADHD
- ☐ AIDS/HIV Positive
- ☐ 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 Troubles
- ☐ Heart Murmur
- ☐ Heart Problems

  Describe _____
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ 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

List any known drug allergies:

_____

_____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor 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 signature on all insurance submissions.

IF ACCOUNT REQUIRES OUTSIDE COLLECTION SERVICE, COLLECTION FEES WILL BE ADDED. THE COLLECTION FEES WILL BE THE RESPONSIBILITY OF GUARANTOR.

_____ _____

Signature of patient or parent if minor Date

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