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

Name: ______ Last Name ______ First Name ______ Middle initial ______ Soc. Sec. #: ______

Address: ______

City: ______ State: ______ Zip: ______ Home Phone: ______

Cell phone: ______ E-Mail: ______

Sex: ☐ M ☐ F Age: ______ Birthdate: ______ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by: ______ Occupation: ______

Business Address: ______ Business Phone: ______

Business E-mail: ______

Whom may we thank for referring you? ______

Notify in case of emergency: ______ Home Phone: ______

Cell Phone: ______ Business Phone: ______

Primary Insurance

Person Responsible for Account: ______ Last Name ______ First Name ______ Middle initial

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

Address (if different from above): ______ Home Phone: ______

City: ______ State: ______ Zip: ______

Cell phone: ______ E-Mail: ______

Person Responsible Employed by: ______ Occupation: ______

Business Address: ______ Business Phone: ______

Business E-mail: ______

Insurance Company: ______ Phone: ______

Insurance Address: ______

Contract #: ______ Group#: ______ Subscriber#: ______

Name of other dependants under this plan: ______

Additional Insurance

Is patient covered by additional insurance: ☐ Yes ☐ No

Subscriber Name: ______ Relation to Patient: ______ Birthdate: ______

Address (if different from above): ______ Soc. Sec.#: ______

City: ______ State: ______ Zip: ______ Home Phone: ______

Cell phone: ______ E-Mail: ______

Subscriber Employed by: ______ Business Phone: ______

Business E-mail: ______

Insurance Company: ______ Phone: ______

Insurance Address: ______

Contract #: ______ Group#: ______ Subscriber#: ______

Name of other dependents under this plan: ______

Dental History

Dentist Name: ______________________ Address: ______________________

Date of last Dental Care: ______________________ Phone: ______________________

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

Check (4) yes or no if you have had problems with any of the following:

- ☐ Y ☐ N **Bad breath**
- ☐ Y ☐ N **Bleeding gums**
- ☐ Y ☐ N **Clicking or popping jaw**
- ☐ Y ☐ N **Food collection between teeth**
- ☐ Y ☐ N **Grinding or clenching teeth**
- ☐ Y ☐ N **Loose teeth or broken fillings**
- ☐ Y ☐ N **Periodontal treatment**
- ☐ Y ☐ N **Sensitivity to cold**
- ☐ Y ☐ N **Sensitivity to hot**
- ☐ Y ☐ N **Sensitivity to sweets**
- ☐ Y ☐ N **Sensitivity when biting**
- ☐ Y ☐ N **Sores or growths in mouth**

What is your main concern for todays visit? ______________________

How do you feel about your smile? ______________________

Have you had braces previously? ______________________

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Y ☐ N

Medical History

Physician's name: ______________________ Phone: ______________________

Date of last visit: ______________________ Have you had any serious illnesses or operations? ☐ Y ☐ N

If yes , describe: ______________________

Are you currently under physician care? ☐ Y ☐ N If yes, describe: ______________________

Have you ever had a blood transfusion? ☐ Y ☐ N If yes, give approximate dates: ______________________

Have you ever taken Fen-Phen/Redux? ☐ Y ☐ N

Women: Are you pregnant? ☐ Y ☐ N Nursing? ☐ Y ☐ N Taking birth control pills? ☐ Y ☐ N

Check (4) yes or no whether you have had any of the following:

- ☐ Y ☐ N **AIDS/HIV**
- ☐ Y ☐ N **Anaphylaxis**
- ☐ Y ☐ N **Anemia**
- ☐ Y ☐ N **Arthritis, Rheumatism**
- ☐ Y ☐ N **Artificial heart valves**
- ☐ Y ☐ N **Artificial joints**
- ☐ Y ☐ N **Asthma**
- ☐ Y ☐ N **Atopic (allergy prone)**
- ☐ Y ☐ N **Back problems**
- ☐ Y ☐ N **Blood disease**
- ☐ Y ☐ N **Cancer**
- ☐ Y ☐ N **Chemical dependency**
- ☐ Y ☐ N **Chemotherapy**
- ☐ Y ☐ N **Circulatory problems**
- ☐ Y ☐ N **Cortisone treatments**
- ☐ Y ☐ N **Cough, persistent**
- ☐ Y ☐ N **Cough up blood**
- ☐ Y ☐ N **Diabetes**
- ☐ Y ☐ N **Epilepsy**
- ☐ Y ☐ N **Fainting**
- ☐ Y ☐ N **Food allergies**
- ☐ Y ☐ N **Glaucoma**
- ☐ Y ☐ N **Headaches**
- ☐ Y ☐ N **Heart murmur**
- ☐ Y ☐ N **Heart problems**

  Describe ______________
- ☐ Y ☐ N **Hemophilia/ Abnormal bleeding**
- ☐ Y ☐ N **Herpes**
- ☐ Y ☐ N **Hepatitis**
- ☐ Y ☐ N **High blood pressure**
- ☐ Y ☐ N **Jaw pain**
- ☐ Y ☐ N **Kidney disease or malfunction**
- ☐ Y ☐ N **Liver disease**
- ☐ Y ☐ N **Material allergies (Latex, wool, metal, chemicals)**
- ☐ Y ☐ N **Mitral valve prolapse**
- ☐ Y ☐ N **Nervous problems**
- ☐ Y ☐ N **Pacemaker/ Heart surgery**
- ☐ Y ☐ N **Psychiatric care**
- ☐ Y ☐ N **Rapid weight gain or loss**
- ☐ Y ☐ N **Radiation treatment**
- ☐ Y ☐ N **Respiratory disease**
- ☐ Y ☐ N **Rheumatic/Scarlet fever**
- ☐ Y ☐ N **Shingles**
- ☐ Y ☐ N **Shortness of breath**
- ☐ Y ☐ N **Skin rash**
- ☐ Y ☐ N **Spina Bifida**
- ☐ Y ☐ N **Stroke**
- ☐ Y ☐ N **Surgical implant**
- ☐ Y ☐ N **Swelling of feet or ankles**
- ☐ Y ☐ N **Thyroid disease or malfunction**
- ☐ Y ☐ N **Tobacco habit**
- ☐ Y ☐ N **Tonsillitis**
- ☐ Y ☐ N **Tuberculosis**
- ☐ Y ☐ N **Ulcer/Colitis**
- ☐ Y ☐ N **Venereal disease**

Is patient currently taking medications? If yes, please list all:

____

____

Does patient have drug allergies? If yes, list all:

____

____

Authorizations

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist 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.

Signature: ______________________ Date: ______________________

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