Welcome

Thank you for your visit today! We appreciate you trusti us t care for your dental health, and are pleased to welcome you to our practice. To hel serve you better, please take a few moments to fill out the following form as complete as you can. If you have any questions, just ask – we will be glad to help. We look forward to working with you!

Patient Information

Date ______________________________ Home Phone ______________________

Name ______________________________ Social Security # ______________________

Address ____

City ____________________ State ____________________ Zip Code ____________________

Sex ☐ Male ☐ Female Age _____ Birthdate _______ ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Occupation ____________________ Employed by ________________________________

Business Address ______________________________ Work Phone ______________________

Whom may we thank for referring you? ______________________________________

Whom may we notify in case of an emergency? ______________________ Phone ______________

Primary Insurance

Who is responsible for this account?

Name ____

Relation to Patient ____________________ Birthdate __________ Social Security # ______________

Address (if different from patient's) ______________________________ Phone ______________

City ____________________ State ____________________ Zip Code ____________________

Employed by ____________________ Occupation ________________________________

Business Address ______________________________ Work Phone ______________________

Insurance Company ____

Contract # ____________________ Group # ____________________ Subscriber # ______________

Names of other dependents covered by this plan ________________________________

Secondary Insurance

Is patient covered by additional insurance? Yes No

Subscriber Name ______________________________ Relation to Patient ______________________

Address (if different from patient's) ______________________________ Phone ______________

City ____________________ State ____________________ Zip Code ____________________

Subscriber Employed by ______________________________ Work Phone ______________________

Insurance Company ______________________________ Social Security # ______________________

Contract # ____________________ Group # ____________________ Subscriber # ______________

Names of other dependents covered by this plan ________________________________

Please Complete Both Sides

DENTAL HEALTH HISTORY

Reason for today's visit ____________________

Previous Dentist ____________________

Address ____________________

Date of last dental care ____________________ Last dental x-rays ____________________

Please check (✓) if you have had trouble 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 Heat
- ☐ 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 ____________________

Previous hospitalizations, illnesses, or operations (please describe, and give approximate date) ____________________

____

Have you ever had a blood transfusion? Yes No If yes, please give approximate date ____________________

Women: Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Please check (✓) if you have or have had any of the following:

Yes	No	Condition
☐	☐	AIDS
☐	☐	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
		Describe ____________
☐	☐	Hemophilia
☐	☐	Hepatitis
☐	☐	High Blood Pressure
☐	☐	HIV Positive
☐	☐	Jaw Pain
☐	☐	Kidney Disease
☐	☐	Liver Disease
☐	☐	Mitral Valve Prolapse
☐	☐	Nervous Problems
☐	☐	Pacemaker
☐	☐	Psychiatric Care
☐	☐	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

Please list any medications you are currently taking ____________________

Please list any allergies ____________________

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 change 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 ____________________

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