

Welcome

Thank you for selecting our dental health care team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental health care needs, please feel out this form completely in ink. If you have any questions or need assistance, please ask us-
We will be happy to help.

Patient Information (CONFIDENTIAL)

Full Name _____
Patient's SS# _____ Birth date _____ Home phone _____ Cell # _____
Address _____ City _____ State _____ Zip _____
Email Address _____ Best number to contact you _____ Best Time _____
Check appropriate status: Minor Single Married

Patient's or Parent's Employer _____ Work phone _____
Business address _____ City _____ State _____
Spouse or Parents Name _____ Employer Work Phone _____
If patient is a student, name of school/college _____ City _____ State _____
Person to contact in case of emergency _____ Phone _____
Whom may we thank for referring you? _____

Responsible Party

Name the person responsible for this account _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Home phone _____ Driver's license _____ Birth date _____
Employer _____ Work/Cell Phone _____
Is this person currently a patient in our office? Yes No

Insurance Information

Name of insured _____ Relationship _____
Birth date _____ Social Security # _____ Date employed _____
Name of employer _____ Work phone _____
Insurance Co. group # _____
Insurance companies address _____ City _____ State _____ Zip _____

Do you have additional insurance? Yes No **If yes--Complete the following**

Name of insured _____ Relationship _____
Birth date _____ Social Security # _____ Date employed _____
Name of employer _____ Work phone _____
Insurance Co. group # _____
Insurance companies address _____ City _____ State _____ Zip _____

Authorization, Release & Agreement to Pay for Services

I authorize and hereby request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me.
I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such a dental care to third party payers and/or other health practitioners. 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 or on behalf of my dependents. I agree to be responsible for payment for all services not paid for by the insurance company after 60 days of receiving said services, I agree to give at least a 24-hour notice for any appointments that I will be unable to keep. I also understand that repeated failure to do so may result in my being charged a broken appointment fee and/or being dismissed from the practice.

Payment is due in full on date of service.

Date _____

Signature of patient or parent if minor

SEE REVERSE

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive

Are you under a physician's care now? Yes No If yes, please explain: _____
 Do you use tobacco? Yes No
 Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
 Do you use controlled substances? Yes No
 Do you need to be pre-medicated before dental treatment? Yes No If yes, Medication taken _____
 Are you on a special diet? Yes No If yes, please explain _____
 Are you taking any medications, pills, or drugs? Yes No If yes, please explain _____

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
Other (If yes, please explain) _____

Do you have, or have you had, any of the following? (please circle)

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting /Dizziness	Yes	No	Kidney Problems	Yes	No	Stroke	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stomach/Int. Disease	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growth	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

WOMEN ONLY Are you:

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Yes No

___ ___ Are you satisfied with the appearance of your teeth?
 ___ ___ Have you ever had an upsetting experience in a dental office?
 ___ ___ Are there anything about dental treatment that bothers you? If yes, what: _____
 ___ ___ Have you ever had any serious accident involving a head, neck, or jaw injury? (Circle all that apply)

Have you ever experienced any of the following: problems in your teeth, mouth or jaws?

___ ___ Clicking, Popping or Pain in the joint of the ear or side of face (Circle all that apply)
 ___ ___ Difficulty in opening, closing, or chewing (Circle all that apply)
 ___ ___ Do you clench or grind your teeth or have frequent headaches? (Circle all that apply)
 ___ ___ Do you have any sores, unhealed injuries, inflamed areas, growths, or lumps in or near your mouth? (Circle)
 ___ ___ Do you feel pain or do your gums bleed when you brush or floss your teeth? (Circle all that apply)
 ___ ___ Are your teeth sensitive to hot, cold, or sour foods/liquids? (Circle all that apply)
 ___ ___ Have you noticed any loosening of your teeth?
 ___ ___ Have you ever had any difficult extractions or prolonged bleeding following extractions in the past?
 ___ ___ Have you ever had braces, oral surgery, gum treatment, or TMJ therapy? (Circle all that apply)

Reason for visit today _____

Chief dental complaints or concerns: _____

When & where was your last dental visit & radiographs? _____

Comments _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT or GUARDIAN _____

DATE _____