

Welcome!

We are pleased to welcome you to our practice. Please take a few minutes and fill out this form. If you have any questions, please ask. We will be glad to help. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ SS# _____
Address _____ Zip _____
Age _____ Birth Date _____ Home Phone () _____ Bus Phone () _____
Email _____ Cell Phone () _____
Whom may we thank for referring you? _____
Employer _____ Occupation _____
Employer's Address _____ Zip _____

Person Responsible for Account

Name _____ SS# _____
Address _____ Zip _____
Age _____ Birth Date _____ Home Phone () _____ Bus Phone () _____
Email _____ Cell Phone () _____
Marital Status Single _____ Married _____ Widowed _____ Separated _____ Divorced _____
Employer _____ Occupation _____
Employer's Address _____ Zip _____

Primary Insurance

Person Responsible for Account: Last Name _____ First Name _____ Initial _____
Driver's License # _____ State _____ Birth Date _____ SS# _____
Relationship to patient _____
Address (if different from patient) _____ Zip _____
Person Responsible Employed By: _____ Occupation _____
Business Address _____ Business Phone () _____
Insurance Company _____
Contract # _____ Group # _____ Subscriber # _____
Other dependents covered under this plan _____

Secondary Insurance

Person Responsible for Account: Last Name _____ First Name _____ Initial _____
Driver's License # _____ State _____ Birth Date _____ SS# _____
Relationship to patient _____
Address (if different from patient) _____ Zip _____
Person Responsible Employed By: _____ Occupation _____
Business Address _____ Business Phone () _____
Insurance Company _____
Contract # _____ Group # _____ Subscriber # _____
Other dependents covered under this plan _____

Authorization

I authorize my insurance company to pay 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 payment is due in full at time of treatment unless prior arrangements have been approved.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Personal / Medical History

Name _____ I like to be called _____ SS# _____
 Address _____, _____, _____ Zip _____
 Age _____ Birthdate _____ Sex: M F Home Phone () _____ Bus Phone () _____
 Email _____ Cell Phone () _____
 Marital Status: Single _____ Married _____ Widowed _____ Separated _____ Divorced _____
 Whom may we thank for referring you? _____
 Employer _____ Occupation _____
 Employer's Address _____, _____, _____ Zip _____
 Physician _____ Address _____ Phone () _____
 In case of emergency please notify: Name _____ Phone () _____
 What is your present health? Good _____ Fair _____ Poor _____ Are you having pain or discomfort at this time? No _____ Yes _____

Check any of the following which you have had or have at present

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Swelling of Ankles | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Radiation Therapy (X-ray, Cobalt) |
| <input type="checkbox"/> Heart Attack or Stroke | <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> Chemotherapy (Cancer, Leukemia) |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> HIV Positive / AIDS |
| <input type="checkbox"/> Chest Pains (Angina) | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Tuberculosis (T.B.) | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Genital Herpes |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Asthma or Hay Fever | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cold Sores |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Skin Rashes or Hives | <input type="checkbox"/> Arthritis or Rheumatism | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Pain in Joints | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fainting or Dizzy Spells | |
| <input type="checkbox"/> Anemia or Hemophilia | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Alcoholism | |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Drug Addiction | |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Cancer or Tumor | |

Do you have any diseases, conditions or problems not list above? No Yes
 If yes, please explain _____

Are you presently taking any prescription or over the counter medications or drugs? No Yes
 If yes, list drug _____

Are you allergic to any medicine, latex, nickel or other substance? No Yes
 If yes, please list _____

Are you now or have you been under the care of a Medical doctor during the last two years? No Yes

Have you ever been hospitalized or had surgery? No Yes

Have you ever had prolonged or unusual bleeding? No Yes

Have you ever had complications or illness following dental treatment? No Yes

Have you ever had an injury or trauma to your

face or jaw? No Yes

Do you smoke or use smokeless tobacco? No Yes

Are you nervous or concerned about having dental work done? No Yes

Women: Are you pregnant now? No Yes
 Due Date _____

Do you anticipate becoming pregnant? No Yes

Dental Treatment Desired (check)

- | | | |
|---|---|--|
| <input type="checkbox"/> Check Up | <input type="checkbox"/> Cleaning | <input type="checkbox"/> Cavities Restored |
| <input type="checkbox"/> Teeth Whitened | <input type="checkbox"/> Teeth Extracted | <input type="checkbox"/> Complete Dentures |
| <input type="checkbox"/> Teeth Straightened | <input type="checkbox"/> Missing Teeth Replaced | |
| <input type="checkbox"/> Other _____ | | |

Best time for dental appointments:

	MON	TUE	WED	THUR	FRI
AM					
PM					

Comments:

To the best of my knowledge, all of the preceding answers are true and correct.

Signature _____ Date _____