WELCOME!

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 forwarding to working with you in maintaining your dental health!

PATIENT INFORMATION

Name____ Social Security #______________________
Last First Initial

Address____ City/State______________________________
Zip Code____________ Email Address____
Preferred contact phone number_______________________________ ☐ Cell ☐ Home ☐ Work
Sex ☐ Male ☐ Female Date of Birth:______________________________ Age______________
☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other
Patient employed by:__________________________________ Occupation______________________
Business address:____________________________________ Phone___________________________
Business email:____
Whom may we thank for referring you?____
Emergency contact____________________________________ Relationship_____________________
Emergency contact phone number____

PRIMARY DENTAL INSURANCE

Person Responsible for Account____
Last Name First Name Initial
SS #________________ DOB________________ Relation to Patient_________________________
Address (if different from patient) ____
City/State_____________________________ Zip Code_______ Contact phone #________________
Person responsible employed by____
Business address_______________________________________ Business phone #______________
Occupation___________________________ Business email_____________________________________
Insurance Company______________________________________ Phone #______________________
Contract #_______________________ Group #_______________ Subscriber #__________________

ADDITIONAL DENTAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No
Subscriber name____
Last Name First name Initial
SS #________________ DOB________________ Relation to Patient_________________________
Address (if different from patient)

____
City/State_____________________________ Zip Code_______ Contact phone #________________
Subscriber employed by____
Business address_______________________________________ Business phone #______________
Occupation___________________________ Business email_____________________________________
Insurance Company______________________________________ Phone #______________________
Contract #_______________________ Group #_______________ Subscriber #__________________

Please complete both sides

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

DENTAL HISTORY

What would you like us to do today?____

Are you in dental discomfort today? ☐ Yes ☐ No If yes, explain________________________

Former Dentist____________________Address________________________

Phone number_______________Date of last dental care/Xrays____________________

Are you having, or have you had problems with any of the following:

☐Y ☐N Bad Breath ☐Y ☐N Food collection between teeth ☐Y ☐N Periodontal Treatment
☐Y ☐N Bleeding gums ☐Y ☐N Grinding or clenching teeth ☐Y ☐N Sensitivity to sweets
☐Y ☐N Sensitivity to hot ☐Y ☐N Sensitivity to cold ☐Y ☐N Clicking/popping jaw
☐Y ☐N Loose teeth ☐Y ☐N Sores/growths in mouth ☐Y ☐N Broken/lost fillings
☐Y ☐N Sensitivity/pain when chewing or biting

How do you feel about the appearance of your teeth?__________________________

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

Other information about your dental health or history________________________

MEDICAL HISTORY

Physician name______________________________Phone____________________

Date of last visit____________Have you ever 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 date______________

Have you ever taken Fen-Phen/Redux? ☐Y ☐N Women: Are you pregnant? ☐Y ☐N
Nursing? ☐Y ☐N Taking birth control? ☐Y ☐N

Do you have, or have you ever had, any of the following?

☐Y ☐N AIDS/HIV positive
☐Y ☐N Anaphylaxis
☐Y ☐N Anemia
☐Y ☐N Arthritis, Rheumatism
☐Y ☐N Artificial heart valve
☐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 loss/gain
☐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, list:

____

____

Does patient have drug allergies? If yes, list:

____

____

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand 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 on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered, except in the case of Blue Cross Blue Shield, whose payments go directly to the patient.

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____________________