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. We look forward to working with you in maintaining your dental health.

Date ______________________ Chart # ______________________

Patient Information

Name ______________________________ Birth date_____/_____/________
First Middle Last

Address ______________________________ Home Phone ______________________

City__________________State________Zip ________ Cell Phone ______________________

Sex ☐ M ☐F Age______Soc.Sec. #______________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient employed by ______________________________Occupation ______________________

Business Address ______________________________ Work Phone__________________Ext.________

Whom may we thank for referring you?______________________________

Notify in case of an Emergency ____________________ Home Phone ____________Cell Phone____________

Name you Prefer______________________________ E-mail ______________________

Account Information

Person Responsible for the Account______________________________
First Middle Last

Relation to Patient ____________________Birth date ____________ Soc. Sec.# ______________

Address (if different from patient)______________________________Home Phone______________________

City ____________________ State __________ Zip __________Cell Phone ______________________

Person responsible employed by ______________________________Occupation ______________________

Business Address______________________________ Work Phone __________________ Ext. ________

Insurance Company ______________________________Phone ______________________

Contract # ____________________ Group # ______________ Subscriber's # ______________

Name(s) of other dependents under this plan ______________________________

Additional Information

Is the patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______________________________ Relation to Patient ____________Birth date ____________

Address (if different than the patient) ______________________________Soc. Sec.# ______________________

City ____________________State ________Zip ______________ Home Phone______________________

Cell Phone ______________________________ Work Phone __________________ Ext. ________

Subscriber Employed By ______________________________

Insurance Company ______________________________Phone ______________________

Contract # ____________________ Group # ______________ Subscriber's # ______________

Name(s) of other dependents under this plan______________________________

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Dental History

Former Dentist ______________________ Address ______________________ Phone ______________________

Date of last dental care ______________________ Date of last X-rays ______________________

Check **Y** for **Yes** and **N** for **No** if you have or have not had the following:

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

How often do you brush? ______________________ How often do you floss?______________________

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

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

Medical History

Physician's name ______________________ Address ______________________ Phone ______________________

Date of last visit Have you had any serious illnesses or operations ☐**Y** ☐**N** If yes, describe ______________________

Are you currently under physician's care? ☐**Y** ☐**N** If yes, describe ______________________

Have you ever had a blood transfusion? ☐**Y** ☐**N** If yes, give approximate date(s) ______________________

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 **Y** for **Yes** or **N** for **No** if you have or have not had the following:

☐**Y** ☐**N** AIDS/HIV Positive
☐**Y** ☐**N** Anemia
☐**Y** ☐**N** Arthritis, Rheumatism
☐**Y** ☐**N** Artificial heart valves
☐**Y** ☐**N** Artificial joints
☐**Y** ☐**N** Asthma
☐**Y** ☐**N** Blood disease
☐**Y** ☐**N** Cancer
☐**Y** ☐**N** Chemical dependency
☐**Y** ☐**N** Chemotherapy

☐**Y** ☐**N** Diabetes
☐**Y** ☐**N** Epilepsy
☐**Y** ☐**N** Glaucoma
☐**Y** ☐**N** Headaches
☐**Y** ☐**N** Heart murmur
☐**Y** ☐**N** Heart problems
Describe ______________
☐**Y** ☐**N** Heart surgery
Describe ______________
☐**Y** ☐**N** Hemophilia

☐**Y** ☐**N** Herpes
☐**Y** ☐**N** Hepatitis
Type ______________
☐**Y** ☐**N** High Blood Pressure
☐**Y** ☐**N** Kidney disease
☐**Y** ☐**N** Liver disease
☐**Y** ☐**N** Low blood pressure
☐**Y** ☐**N** Mitral valve prolapse
☐**Y** ☐**N** Pacemaker
☐**Y** ☐**N** Psychiatric care

☐**Y** ☐**N** Radiation treatment
☐**Y** ☐**N** Respiratory Disease
☐**Y** ☐**N** Rheumatic fever
☐**Y** ☐**N** Scarlet fever
☐**Y** ☐**N** Shortness of breath
☐**Y** ☐**N** Sinus problems
☐**Y** ☐**N** Stroke
☐**Y** ☐**N** Thyroid disease
☐**Y** ☐**N** Tobacco habit
☐**Y** ☐**N** Tuberculosis

Check the boxes of the following that you are allergic to or suffer ill effects from: Penicillin Codeine Latex gloves Sulfa drugs

Aspirin Dental Anesthesia Others (Please list) ______________________

LIST ALL MEDICATIONS (prescribed & over the counter) **THAT YOU ARE CURRENTLY TAKING:** ______________________

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Check the boxes of the following that you are taking: Aspirin (325mg) Coumadin Wayfarin/ Heparin Baby Aspirin (81mg)

Plavix Other blood thinners: ______________________

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I also understand that this information will be held in the strictest of confidence according to HIPPA regulations and that it is my responsibility to inform this office of nay medical or medication changes.

I authorize my insurance company to pay to 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 I am financially responsible for all changes whether or not paid by insurance.

Signature ______________________ Date ______________________

Payment is due in full when services are rendered.