Welcome

Thank you for selecting us.

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name____________________ Date__________

SS#__________ Birthdate__________ Home Phone__________

Address__________ City__________ State______ Zip__________

Email____________________ Cell Phone__________

What is the best number to contact you at during the day? ____________________

Check: ___Minor ___Single ___Married ___Separated ___Divorced ___Widowed

If student, school/college__________ City__________ State______ ___FT ___PT

Patient or Parent/Guardian's Employer __________ Work Phone__________

Business Address__________ City__________ State______ Zip__________

Spouse or Parent/Guardian's Name __________ Employer __________ Work Phone__________

Whom may we thank for referring you?____________________

Person to contact in case of emergency__________ Phone__________

Responsible Party-Insurance Information

Name of person responsible for this account __________ Relationship to Patient__________

Address____________________ Home Phone__________

Email__________ Birthdate__________ Cell Phone__________

Employer__________ SS#__________ Work Phone__________

Insurance Company __________ Group #__________ Policy ID#__________

Ins. Co. Address__________ City__________ State __________ Zip Code__________

Deductible__________ Annual Maximum__________ Amount used __________

Patient Medical History

Physician__________ Office Phone __________ Date of Last exam__________

	Yes	No
1. Are you under medical treatment now?	___	___
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	___	___
If yes, please explain__________		
3. Are you taking any medications including non-Prescription medicine?	___	___
If yes, what medications are you taking?__________		
4. Have you ever taken Fen-Phen/Redux?	___	___
5. Women only: Are you pregnant/ think you may be?	___	___
Are you nursing?	___	___
Are you taking oral contraceptives?	___	___
6. Do you use tobacco products?	___	___
7. Do you use controlled substances?	___	___

8. Are you allergic to or had any reactions to the following:	Yes	No
Local Anesthetics (e.g. Novocain)	___	___
Penicillin or any other Antibiotic	___	___
Sulfa Drugs	___	___
Barbiturates	___	___
Sedatives	___	___
Iodine	___	___
Aspirin	___	___
Any Metals (e.g. nickel, mercury, etc)	___	___
Latex Rubber	___	___
Other__________		
9. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	___	___
10. Are you wearing contact lenses?	___	___

11.Do you have or have you had the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	___	___	Heart Disease	___	___	Chest Pain	___	___
Heart Attack	___	___	Cardiac Pacemaker	___	___	Easily Winded	___	___
Rheumatic Fever	___	___	Heart Murmur	___	___	Stroke	___	___
Swollen Ankles	___	___	Angina	___	___	Hay Fever/Allergies	___	___
Fainting/Seizures	___	___	Frequently Tired	___	___	Tuberculosis	___	___
Asthma	___	___	Anemia	___	___	Radiation Therapy	___	___
Low Blood Pressure	___	___	Emphysema	___	___	Glaucoma	___	___
Epilepsy/Convulsions	___	___	Cancer	___	___	Recent Weight Loss	___	___
Leukemia	___	___	Arthritis	___	___	Liver Disease	___	___
Diabetes	___	___	Joint Replacement/Implant	___	___	Heart Trouble	___	___
Kidney Disease	___	___	Hepatitis/Jaundice	___	___	Respiratory Problem	___	___
AIDS or HIV infection	___	___	Sexually Transmitted Disease	___	___	Mitral Valve Prolapse	___	___
Thyroid Problems	___	___	Stomach Troubles/Ulcers	___	___	Other __________	___	___

Patient Dental History

Name of Previous Dentist and Location ____ Date of Last Exam ________________________________

	Yes	No
1. Do your gums bleed while brushing or flossing?	___	___
2. Are your teeth sensitive to hot or cold liquids/foods?	___	___
3. Are your teeth sensitive to sweet or sour liquids/foods?	___	___
4. Do you feel pain to any of your teeth?	___	___
5. Do you have any sores or lumps in or near your mouth?	___	___
6. Have you had any head, neck or jaw injuries?	___	___
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	___	___
Pain (joint, ear, side of face)	___	___
Difficulty in opening or closing	___	___

	Yes	No
8. Do you have frequent headaches?	___	___
9. Do you clench or grind your teeth?	___	___
10. Do you bite your lips or cheeks frequently?	___	___
11. Have you ever had any difficult extractions in the past?	___	___
12. Have you ever had any prolonged bleeding following extractions?	___	___
13. Have you had any orthodontic treatments?	___	___
14. Do you wear partials or dentures?	___	___
If yes, date of placement________________________		
15. Have you ever had a bad dental experience?	___	___
16 Do you like your smile?	___	___

Authorization and Release

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or nay other member of his/her team responsible for any errors or omissions that I may have made in the completion of these forms. I authorize use of my signature on all my insurance submissions. I authorize release of dental information to all my insurance carriers. I understand that I am responsible for my bill. I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers. I authorize payment directly to my doctor.

____ ____

Signature of Patient Name (Print)

____ ____

Signature of Office Representative Name (Print)