

# 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? _____   | 8. Are you allergic to or had any reactions to the following:   | Yes   | No    |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? _____<br>If yes, please explain _____ | Local Anesthetics (e.g. Novocain) _____   | _____ | _____ |
| 3. Are you taking any medications including non-Prescription medicine? _____<br>If yes, what medications are you taking? _____                  | Penicillin or any other Antibiotic _____  | _____ | _____ |
| 4. Have you ever taken Fen-Phen/Redux? _____  | Sulfa Drugs _____   | _____ | _____ |
| 5. Women only: Are you pregnant/ think you may be? _____<br>Are you nursing? _____  | Barbiturates _____  | _____ | _____ |
| 6. Do you use tobacco products? _____   | Sedatives _____   | _____ | _____ |
| 7. Do you use controlled substances? _____  | 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	_____	_____	Empysema	_____	_____	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		Yes	No
1. Do your gums bleed while brushing or flossing?	___	___	8. Do you have frequent headaches?	___	___
2. Are your teeth sensitive to hot or cold liquids/foods?	___	___	9. Do you clench or grind your teeth?	___	___
3. Are your teeth sensitive to sweet or sour liquids/foods?	___	___	10. Do you bite your lips or cheeks frequently?	___	___
4. Do you feel pain to any of your teeth?	___	___	11. Have you ever had any difficult extractions in the past?	___	___
5. Do you have any sores or lumps in or near your mouth?	___	___	12. Have you ever had any prolonged bleeding following extractions?	___	___
6. Have you had any head, neck or jaw injuries?	___	___	13. Have you had any orthodontic treatments?	___	___
7. Have you ever experienced any of the following problems in your jaw?			14. Do you wear partials or dentures?	___	___
Clicking	___	___	If yes, date of placement _____		
Pain (joint, ear, side of face)	___	___	15. Have you ever had a bad dental experience?	___	___
Difficulty in opening or closing	___	___	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)