# Welcome!

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

## Patient Information

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____ Home Phone _____
Last Name First Name Initial

Address _____ Cell Phone _____

City _____ State _____ Zip _____ E-mail _____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

## Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

## Additional Insurance

Insured Name _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

# Dental History

Former Dentist _____ Date of Last X-Rays _____

City, State _____ How Often Do You Floss? _____

Date of Last Dental Visit _____ How Often Do You Brush? _____

Please check all that apply:

| | | |
|---|---|---|
| Bad Breath ☐ | Loose Teeth or Broken Fillings ☐ | Sensitivity to Sweets ☐ |
| Bleeding Gums ☐ | Orthodontic Treatment ☐ | Sensitivity When Biting ☐ |
| Blisters on Lips or Mouth ☐ | Pain Around Ear ☐ | Frequent Headaches ☐ |
| Finger Nail Biting ☐ | Periodontal Treatment ☐ | Jaw, Head or Neck Injuries ☐ |
| Grinding Teeth ☐ | Sensitivity to Cold ☐ | Jaw Difficulty: Clicking and/or Pain ☐ |
| Lip or Cheek Biting ☐ | Sensitivity to Heat ☐ | Tooth Pain ☐ |

# Medical History

Physician's Name _____ Date of Last Visit _____

| | Yes | No |
|---|---|---|
| 1. Are you currently under medical treatment? | ☐ | ☐ |
| 2. Have you ever had any serious illnesses or operations? | ☐ | ☐ |
| 3. Are you currently taking any medication? | ☐ | ☐ |

Please describe: _____

_____

| | | |
|---|---|---|
| 4. Do you smoke? | ☐ | ☐ |
| 5. Do you use alcohol, cocaine or other drugs? | ☐ | ☐ |
| 6. Do you wear contact lenses? | ☐ | ☐ |

7. Have you had any allergic reactions to the following:

| | Yes | No |
|---|---|---|
| Local Anesthetics (eg. novocaine) | ☐ | ☐ |
| Penicillin or other Antibiotics | ☐ | ☐ |
| Sulfa Drugs | ☐ | ☐ |
| Barbiturates (sleeping pills) | ☐ | ☐ |
| Sedatives | ☐ | ☐ |
| Iodine | ☐ | ☐ |
| Aspirin | ☐ | ☐ |
| Other | ☐ | ☐ |

8. (Women Only) Are You:

| | | |
|---|---|---|
| Pregnant? | ☐ | ☐ |
| Nursing? | ☐ | ☐ |
| Taking birth control pills? | ☐ | ☐ |

Please check all that apply:

| | | |
|---|---|---|
| AIDS ☐ | Emphysema ☐ | Pacemaker ☐ |
| Anemia ☐ | Epilepsy ☐ | Psychiatric Care ☐ |
| Arthritis, Rheumatism ☐ | Fainting or Dizziness ☐ | Radiation Treatment ☐ |
| Artificial Heart Valves ☐ | Glaucoma ☐ | Respiratory Disease ☐ |
| Artificial Joints ☐ | Headaches ☐ | Rheumatic Fever ☐ |
| Asthma ☐ | Heart Murmur ☐ | Scarlet Fever ☐ |
| Back Problems ☐ | Heart Problems ☐ | Shortness of Breath ☐ |
| Bleeding abnormally, with extractions or surgery ☐ | Hepatitis-Type _____ ☐ | Sinus Trouble ☐ |
| Blood Disease ☐ | Herpes ☐ | Skin Rash ☐ |
| Cancer ☐ | High Blood Pressure ☐ | Stroke ☐ |
| Chemical Dependency ☐ | HIV Positive ☐ | Swelling of Feet/Ankles ☐ |
| Chemotherapy ☐ | Jaundice ☐ | Swollen Neck Glands ☐ |
| Chronic Fatigue Syndrome ☐ | Jaw Pain ☐ | Thyroid Problems ☐ |
| Circulatory Problems ☐ | Kidney Disease ☐ | Tonsillitis ☐ |
| Congenital Heart Lesions ☐ | Latex Sensitivity ☐ | Tuberculosis ☐ |
| Cortisone Treatments ☐ | Liver Disease ☐ | Tumor or growth on head/neck ☐ |
| Cough - persistent or bloody ☐ | Low Blood Pressure ☐ | Ulcer ☐ |
| Diabetes ☐ | Mitral Valve Prolapse ☐ | Venereal Disease ☐ |
| | Nervous Problems ☐ | |

# Assignment and Release

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____