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We are pleased to welcome you to our practice.
Thank you for taking the time to fill out this form prior to arrival. Please call us with any questions.

Patient Information:

Date: _____
Name: _____ Social Security #: _____
Last Name First Name Middle Initial
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Email: _____
Sex: ❑ Male ❑ Female Age: _____ Birthdate: _____ ❑ Single ❑Married ❑Separated ❑Divorced
Patient's Employer: _____Occupation: _____
Business Address: _____ Business Phone: _____
Whom may we thank for referring you? _____
In case of emergency, who should be notified? _____Phone: _____

Primary Insurance:

Responsible Party: _____ Relation to Patient: _____
Last Name First Name Middle Initial
Birthdate: _____ Social Security Number: _____
Address: (If different than patient's) _____
City: _____ State: _____ Zip Code: _____
Responsible Party's Employer: _____ Occupation: _____
Business Address: _____ Business Phone: _____
Insurance Company: _____ Contact Number: _____
Group Number: _____ Subscriber #: _____
Names of other dependents covered: _____

Additional/Secondary Insurance (if patient is covered):

Subscriber Name: _____ Relation to Patient: _____
Last Name First Name Middle Initial
Birthdate: _____ Social Security Number: _____
Address: (If different than patient's) _____
City: _____ State: _____ Zip Code: _____
Business Address: _____ Business Phone: _____
Insurance Company: _____ Contact Number: _____
Group Number: _____ Subscriber #: _____
Names of other dependents covered: _____

Dental History:

Reason for Today's Visit: _____
Former Dentist: _____
Address: _____
Date of last dental care: _____ Date of last dental x-rays: _____

Check (✓) if you had problems with any of the following:

- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Clicking or popping teeth
- ❑ Food Collection between teeth
- ❑ Grinding teeth
- ❑ Loose teeth or broken filings
- ❑ Periodontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to heat
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sores/growths in your mouth

How often do you floss? _____ How often do you brush? _____

Medical History:

Physician's Name: _____Date of Last Visit: _____
Any Serious Illnesses or operations? ❑ Yes ❑ No If yes, describe: _____
Have you ever had a blood transfusion? ❑ Yes ❑ No If yes, give approx. date: _____
(Women) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking Birth Control Pills? ❑ Yes ❑ No

Check (✓) if you have or have had any of the following:

- ❑ Anxiety
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Blood Disease
- ❑ Cancer Date/Type: _____
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Cortisone Treatments
- ❑ Cough, Persistent
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart Problems
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Jaw Pain
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mitral Valve Prolapse
- ❑ Nervous Problems
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Shortness of Breath
- ❑ Skin Rash
- ❑ Stroke
- ❑ Swelling of Feet/Ankles
- ❑ Thyroid Problems
- ❑ Tobacco Habit
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Venereal Disease

Medications: Please list all medications / supplements

_____
_____

Allergies:

_____
_____

Authorization:

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 charges whether or not paid by insurance. **Payment is due in full at time of treatment unless prior arrangements have been approved.**

Signature: _____ Date: _____