Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

_____ Date

Patient Information

Name_____ Birthdate_____ Home Phone_____
Address_____ City_____ State_____ Zip_____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Patient's or Parent's Employer_____ Work Phone_____
Business Address_____ City_____ State_____ Zip_____
Spouse or Parent's Name_____ Employer_____ Work Phone_____
If Patient is a Student, Name of School/College_____ City_____ State_____
Cell Phone #_____ Email Address_____

Name of Person Responsible for this Account_____ Relation to Patient_____
Address_____ Home Phone_____
Whom May We Thank for Referring You?_____

Insurance Information

Name of Insured_____ Relation to Patient_____
Birthdate_____ Social Security #_____ Date Employed _____
Employer_____ Work Phone_____
Employer Address_____ City_____ State_____ Zip_____
Insurance Company_____ Group #_____ Union or Local #_____
Address_____ City_____ State_____ Zip_____
How Much is Your Deductible?_____ How Much Have You Used?_____ Max. Annual Benefit _____

Dental History

Reason for today's visit_____
Former Dentist_____
Address_____
Date of last dental visit_____ Date of last dental X-rays_____

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

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between the teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

Is there something you don't like about your teeth or smile? Let me know. We can correct it! _____

OVER

Medical History

Physician's Name_____ Date of last visit_____

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe_____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates_____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

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

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Fen-Phen
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
  Describe_____
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

Medications

List medications you are currently taking:

_____

_____

Allergies

_____

_____

Authorization and Release

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I authorize the doctor 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. If for any reason we have not received your insurance carrier payment within 90 days of claim, the remaining balance is due and payable by you. I further understand and agree to pay reasonable interest, court costs and attorney fees in event I am delinquent for more than 30 days after presentment of bill for services rendered.

_____ _____

Signature of patient or parent if minor Date

Payment is due in full at time of treatment unless prior arrangements have been approved.