

# W E L C O M E

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

## PATIENT INFORMATION

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
*Last Name First Name Initial*

Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Sex ☐ M ☐ F Age \_\_\_\_\_ Birthdate \_\_\_\_\_ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_  
Business Email \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Notify in case of emergency \_\_\_\_\_ Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Business Phone \_\_\_\_\_  
Email \_\_\_\_\_

## PRIMARY INSURANCE

Person Responsible for Account \_\_\_\_\_  
*Last Name First Name Initial*

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address (if different from patient) \_\_\_\_\_ Home Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_  
Business Email \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_  
Insurance Email \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Name of other dependents under this plan \_\_\_\_\_

## ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address (if different from patient) \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Subscriber Employed by \_\_\_\_\_ Business Phone \_\_\_\_\_  
Business Email \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_  
Insurance Email \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Name of other dependents under this plan \_\_\_\_\_

Please complete both sides.

# DENTAL HISTORY

What would you like us to do today? \_\_\_\_\_ Are you in dental discomfort today? \_\_\_\_\_

Former Dentist \_\_\_\_\_ Address \_\_\_\_\_

Dentist's Email \_\_\_\_\_ Phone \_\_\_\_\_

Date of last dental care \_\_\_\_\_ Date of last x-rays \_\_\_\_\_

Check (✓) yes or no if you have had problems with any of the following:

<input type="checkbox"/> Y <input type="checkbox"/> N Bad breath	<input type="checkbox"/> Y <input type="checkbox"/> N Food collection between teeth	<input type="checkbox"/> Y <input type="checkbox"/> N Periodontal treatment	<input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets
<input type="checkbox"/> Y <input type="checkbox"/> N Bleeding gums	<input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching teeth	<input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to cold	<input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting
<input type="checkbox"/> Y <input type="checkbox"/> N Clicking or popping jaw	<input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth or broken fillings	<input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to hot	<input type="checkbox"/> Y <input type="checkbox"/> N Sores or growths in mouth

How often do you brush? \_\_\_\_\_ Floss? \_\_\_\_\_

How do you feel about the appearance of your teeth? \_\_\_\_\_

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Y ☐ N

Other information about your dental health or previous treatment \_\_\_\_\_

# MEDICAL HISTORY

Physician's name \_\_\_\_\_ Phone \_\_\_\_\_

Date of last visit \_\_\_\_\_ Have you had any serious illnesses or operations? ☐ Y ☐ N

If yes, describe \_\_\_\_\_

Are you currently under physician care? ☐ Y ☐ N If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion? ☐ Y ☐ N If yes, give approximate dates: \_\_\_\_\_

Women: Are you pregnant? ☐ Y ☐ N Nursing? ☐ Y ☐ N Taking birth control pills? ☐ Y ☐ N

Check (✓) yes or no whether you have had any of the following:

<input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive	<input type="checkbox"/> Y <input type="checkbox"/> N Cough, persistent	<input type="checkbox"/> Y <input type="checkbox"/> N Jaw pain	<input type="checkbox"/> Y <input type="checkbox"/> N Hives
<input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis	<input type="checkbox"/> Y <input type="checkbox"/> N Cough up blood	<input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease or malfunction	<input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath
<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N Liver disease	<input type="checkbox"/> Y <input type="checkbox"/> N Skin rash
<input type="checkbox"/> Y <input type="checkbox"/> N Arthritis, Rheumatism	<input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N Material allergies (latex, wool, metal, chemicals)	<input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Anemia
<input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves	<input type="checkbox"/> Y <input type="checkbox"/> N Fainting	<input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse	<input type="checkbox"/> Y <input type="checkbox"/> N Stroke
<input type="checkbox"/> Y <input type="checkbox"/> N Artificial joints	<input type="checkbox"/> Y <input type="checkbox"/> N Food allergies	<input type="checkbox"/> Y <input type="checkbox"/> N Nervous problems	<input type="checkbox"/> Y <input type="checkbox"/> N Surgical implant
<input type="checkbox"/> Y <input type="checkbox"/> N Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker/Heart surgery	<input type="checkbox"/> Y <input type="checkbox"/> N Swelling of feet/ankles
<input type="checkbox"/> Y <input type="checkbox"/> N Atopic (allergy prone)	<input type="checkbox"/> Y <input type="checkbox"/> N Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric care	<input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease or malfunction
<input type="checkbox"/> Y <input type="checkbox"/> N Back problems	<input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur	<input type="checkbox"/> Y <input type="checkbox"/> N Rapid weight gain or loss	<input type="checkbox"/> Y <input type="checkbox"/> N Tobacco habit
<input type="checkbox"/> Y <input type="checkbox"/> N Blood disease	<input type="checkbox"/> Y <input type="checkbox"/> N Heart problems	<input type="checkbox"/> Y <input type="checkbox"/> N Radiation treatment	<input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis
<input type="checkbox"/> Y <input type="checkbox"/> N Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N Describe _____	<input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease	<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis
<input type="checkbox"/> Y <input type="checkbox"/> N Chemical dependency	<input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/Abnormal bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet fever	<input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/Colitis
<input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N Herpes		<input type="checkbox"/> Y <input type="checkbox"/> N Urinary disease
<input type="checkbox"/> Y <input type="checkbox"/> N Circulatory problems	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis		
<input type="checkbox"/> Y <input type="checkbox"/> N Cortisone treatments	<input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure		

Is patient currently taking any medications? If yes, list all: \_\_\_\_\_

Does patient have drug allergies? If yes, list all: \_\_\_\_\_

# AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist 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. If turned over to a collection agency, patient is responsible for all collection costs incurred. Finance charged after three months at the rate of 18%.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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

# Patient Consent & Authorization for Release of Protected Health Information

Please Print

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

## Patient Authorization

I, \_\_\_\_\_, hereby authorize the release, use or disclosure of my health information as follows:

This authorization pertains to the following type of medical information about me:

\_\_\_\_\_  
\_\_\_\_\_

I hereby authorize \_\_\_\_\_  
Name of individual(s) and/or organization providing information

to release the above-described information to \_\_\_\_\_  
Name of individual(s) and/or organization receiving this information

I understand that, per my request, this authorization will permit the above-named parties to use or disclose the identified health information for purposes beyond treatment, payment, or healthcare operations as provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that I may revoke this authorization at any time by providing written notification to:

\_\_\_\_\_

The revocation will be effective on the date it has been received and processed by the above-named recipient. I understand that the revocation does not apply to actions taken in reliance upon this authorization prior to the effective date of revocation. I also understand that I do not have to sign this authorization in order to receive treatment, payment, or to enroll or be eligible for benefits.

Unless I request in writing otherwise, I understand that this authorization will expire on \_\_\_\_\_. If I do not  
Expiration date or event  
specify an expiration date or event, this authorization will expire ninety (90) days from the date on which I signed this authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the named recipient, and may no longer be protected by HIPAA's privacy rules after the authorized disclosure.

## Patient or Personal Representative

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_  
Please Print

Relationship to Patient: \_\_\_\_\_

## For Office Use Only

Received by: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_