Welcome

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.

Soc. Sec. # _____

Name _____ Date _____ Sex ☐ Male ☐ Female
Address _____ City _____ State _____ Zip _____
Date of Birth _____ Age _____ Home phone # _____ Work phone# _____
Do you prefer to receive calls at: Home Work Either Cell phone # _____
Are you: Minor Married Divorced Widowed Single Separated
Your or your parent's employer _____ Occupation _____
Business Address _____ City _____ State _____ Zip _____
Spouse's or parent's name _____ Workplace _____ Work phone# _____
If you are a student, name of school/college _____ City _____ State _____
Whom may we thank for referring you to us? _____
Person to contact in case of emergency _____ Phone # _____

Primary Insurance

Person Responsible for Account _____
Last Name *First Name* *Initial*
Relation to Patient _____ Date of Birth _____ Soc. Sec. # _____
Address(if different from patient) _____ Home Phone _____
City _____ State _____ Zip _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Insurance Company _____ Phone _____
Driver's License # _____ Group # _____ Subscriber # _____

Additional Insurance

Is patient covered by additional insurance? Yes No
Subscriber Name _____ Relation to Patient _____ Date of Birth _____
Address(if different from patient) _____ Soc. Sec. # _____
City _____ State _____ Zip _____ Phone _____
Subscriber Employed by _____ Business Phone _____
Insurance Company _____ Phone _____
Contract # _____ Group # _____ Subscriber # _____

Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____
Former Dentist _____ Phone _____ Date of last dental care _____
Check ( ) if you have had problems with any of the following:

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

Do you wear partials or dentures? Y N If so how old? _____
Are you interested in a brighter smile? Y N
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 _____

Please complete both sides

Medical History

Physician _____ Address _____

Telephone _____ Date of last physical examination _____

CIRCLE

1. Are you having pain or discomfort at this time? ..... YES NO
2. Do you feel very nervous about having dentistry treatment? ..... YES NO
3. Have you ever had a bad experience in the dentistry office? ..... YES NO
4. Have you been a patient in the hospital during the past two years? ..... YES NO
5. Have you been under the care of a medical doctor during the past two years? ..... YES NO
6. Have you taken any medicine or drugs during the past two years? ..... YES NO
7. Are you allergic to (i.e., itching, swelling of hands, feet, or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? ..... YES NO
8. Have you ever had any excessive bleeding requiring special treatment? ..... YES NO
9. Have you ever taken the medication Phen-fen? ..... YES NO
10. Circle any of the following which you have had or have at present:

Heart Failure ..... YES NO	Kidney Trouble ..... YES NO	HIV ..... YES NO
Heart Disease or Attack ..... YES NO	Ulcers ..... YES NO	AIDS ..... YES NO
Angina Pectoris ..... YES NO	Emphysema ..... YES NO	Hepatitis A (infectious) ..... YES NO
High Blood Pressure ..... YES NO	Cough ..... YES NO	Hepatitis B (serum) ..... YES NO
Heart Murmur ..... YES NO	Tuberculosis (TB) ..... YES NO	Hepatitis C ..... YES NO
Mitro Valve Prolapse ..... YES NO	Asthma ..... YES NO	Liver Disease ..... YES NO
Rheumatic Fever ..... YES NO	Hay Fever ..... YES NO	Yellow Jaundice ..... YES NO
Congenital Heart Lesions ..... YES NO	Sinus Trouble ..... YES NO	Blood Transfusion ..... YES NO
Scarlet Fever ..... YES NO	Allergies or Hives ..... YES NO	Drug Addiction ..... YES NO
Artificial Heart Valve ..... YES NO	Diabetes ..... YES NO	Hemophilia ..... YES NO
Heart Pacemaker ..... YES NO	Thyroid Disease ..... YES NO	Venereal Disease(Syphilis, Gonorrhea) ..... YES NO
Heart Surgery ..... YES NO	X-ray or Cobalt Treatment ..... YES NO	Cold Sores ..... YES NO
Artificial Joint(hip, knee, etc)	Chemotherapy(Cancer, Leukemia) ..... YES NO	Genital Herpes ..... YES NO
Surgery Date : _____	Arthritis ..... YES NO	Epilepsy or Seizures ..... YES NO
Implanted plates, screws, pins, etc	Rheumatism ..... YES NO	Fainting or Dizzy Spells ..... YES NO
Surgery Date : _____	Cortisone Medicine ..... YES NO	Nervousness ..... YES NO
Anemia ..... YES NO	Glaucoma ..... YES NO	Psychiatric Treatment ..... YES NO
Stroke ..... YES NO	Pain in Jaw Joints ..... YES NO	Sickle Cell Disease ..... YES NO
		Bruise Easily ..... YES NO

11. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? ..... YES NO
12. Do your ankles swell during the day? ..... YES NO
13. Do you use more than 2 pillows to sleep? ..... YES NO
14. Have you lost or gained more than 10 pounds during the past year? ..... YES NO
15. Do you ever wake up from sleep short of breath? ..... YES NO
16. Are you on a special diet? ..... YES NO
17. Has your medical doctor ever said you have a cancer or tumor? ..... YES NO
18. Do you have any disease, condition, or problem not listed? ..... YES NO
19. WOMEN: Are you pregnant now? ..... YES NO How many months ? _____
    Are you practicing birth control? ..... YES NO
    Do you anticipate becoming pregnant? ..... YES NO

List Medications Taking _____

_____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of 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. I understand the x-rays are the property of the dentist and there may be a duplication fee, if necessary.

Signature _____ Date _____

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

History Review Office Use Only Patient needs to premedicate ☐ yes ☐ no

Doctor Signature _____ Date _____

MEDICAL HISTORY / PHYSICAL EVALUATION UPDATE

Date	*Addition*	*Signature of Patient, Parent or Guardian*
_____	_____	_____
_____	_____	_____
_____	_____	_____