W E L C O M E

Patient Information

Thank you for choosing our practice for your dental needs. Please complete the front and back of this form. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Please Print

Date____________________

Name____ Social Security # _________-______-________
First Middle Last

Address____ City______________________ State______ Zip_____________

Birth date ___________________________ Home Phone # ( ) ________________________________

Cell Phone # ( ) ________________________________

e-mail address: ____________________________________ Work Phone # ( ) _____________________EXT________

Are you: [ ] Minor [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Employer (If patient is a minor, Parent's Employer) ____________________________________ Occupation______________________
Business Address____ City __________________ State______ ZIP __________
Spouse's or Parent's name _______________________________ Workplace____________________ Work Phone______________
If you are presently in college, do you attend school: [ ] Full-time [ ] Part-time

How did you hear about us? (If it is through a friend, please provide name) ____
Person to contact in case of emergency____ Phone# ( ) __________________

Responsible Party

If Self, check here [ ] and proceed to next section. If you are over the age of 18 and someone else is legally responsible for your account, then please provide copy of legal documentation to verify this claim.

Name of person responsible for this account if other than self ____
Relationship to patient ____________________________ Social Security # _______-____-_______ Phone #( ) ______-________
Address ____ City ____________________ State _______ ZIP _________
Name of Employer ____ Work phone # ( ) ________-__________ EXT _______

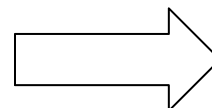
Insurance Information

[ ] I do not have dental insurance
[ ] I am covered by 1 dental insurance Name of Primary Insurance __________________________________
[ ] I am covered by more than 1 dental insurance Name of Secondary Insurance ________________________________

Please provide us with your insurance card(s).
If you do not have the insurance card(s), then we need to know the following for each of the insurance that you have:

1. Subscriber's Name and Employer Name
2. Subscriber's Social security number or Insurance ID Number
3. Subscriber's Birth date
4. Name of Insurance Company and phone number

CONTINUE ON BACK



C O N F I D E N T I A L

Dental History

Reason for today's visit____

Date of Last Exam___________________________ Date of last dental X-Rays___________________________

How often do you brush?_________________ _______ How often do you floss? ____________________________

Please check any of the following conditions that apply to you:

[ ] Bad Breath
[ ] Grinding teeth
[ ] Sensitivity to hot or cold or sweets
[ ] Bleeding gums
[ ] Loose teeth or broken fillings
[ ] Food impaction between teeth
[ ] Clicking / popping jaw
[ ] Periodontal/ gum treatment
[ ] Pain when biting

Are you happy with the appearance of your smile? [ ] Yes
[ ] No – Please explain why ________________________________

____

Are you interested in whitening your teeth? [ ] Yes [ ] No

Medical History

Physician's name ____ Phone # ( ) _________________

Physician's Address ___________________________________ City_______________ State_____ ZIP _________

Date of last exam/ physical _________________________________

Are you ALLERGIC to any medications? If yes, please list medications ______________________________

Please list all medications you are taking: ____

____

Women: Are you pregnant? [ ] Yes [ ] No Taking birth control pills? [ ] Yes [ ] No

Do you have or ever had a history of the following?

[ ] Heart problems
[ ] High blood pressure
[ ] HIV positive/AIDS
[ ]Cancer
[ ] Artificial Heart Valves
[ ] Stroke
[ ] Hepatitis
[ ] Chemotherapy
[ ] Heart murmur
[ ] Low blood pressure
[ ] Kidney disease
[ ] Radiation treatment
[ ] Rheumatic heart disease
[ ] Fainting
[ ] Liver Disease
[ ] Psychiatric care
[ ] Artificial joints (pins/plates)
[ ] Circulatory problems
[ ] Hemophilia
[ ] Tobacco habits
[ ] Mitral valve prolapsed
[ ] Swelling of feet/ ankles
[ ] Epilepsy
[ ] Chemical dependency
[ ] Pacemaker
[ ] Shortness of breath
[ ] Arthritis
[ ] Diabetes
[ ] Asthma

Were you ever told to take antibiotics before dental visits (premedication)? [ ] Yes [ ] No

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care, to third party payers and/ or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that any account balances not paid in full within 30 days may be assessed a 1.5% monthly finance charge. If my account becomes delinquent and is sent to a third party collection agency, I understand I will be responsible for all fees incurred.

X____ _________________

Signature of Patient/ Guardian *Date*