Welcome To Our Practice

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 any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date: _____ Home Phone: (___)_____ Cell Phone (____)_____

Name: _____ Soc. Sec. #:_____
First Middle Initial Last

Birth date: _____ Sex: ☐ Male ☐ Female Status: ☐ Minor ☐ Single ☐ Married ☐ Partnered

Address: _____

City: _____ State: _____ Zip: _____ Email_____

Patient Employer/School: _____ Occupation: _____

Employer/School Address: _____ Phone: (____)_____

Relative/close friend in case of emergency: _____ Phone: (____) _____

Medical Doctor: _____ Phone: (____)_____ Medical #: _____

Referred By: _____

Primary Insurance

Person responsible for account: _____
First Middle Initial Last

Relation to patient:_____ Birth date: _____ Soc. Sec. #: _____

Address (if different from patient's): _____ Phone: (____)_____

City: _____ State: _____ Zip:_____

Employer Name: _____ Occupation: _____

Employer Address: _____ Phone: _____

Insurance Carrier: _____ Group #: _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No Subscriber Name: _____

Soc Sec #: _____ Birth date: _____ Relation: _____

Address (if different from patient's): _____ Phone: (____)_____

City: _____ State: _____ Zip:_____

Employer Name: _____ Occupation: _____

Employer Address: _____ Phone: _____

Insurance Carrier: _____ Group #: _____

Dental History

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

☐ Bad breath	☐ Clicking/popping/painful jaw joints	☐ Loosening of teeth
☐ Bleeding gums	☐ Discomfort &/or trouble opening mouth wide	☐ Pain &/or swelling of gums
☐ Clenching &/or grinding teeth	☐ Food collection between teeth	☐ Sensitivity to hot/cold/sweets

Have you had any periodontal treatment in the past? ☐ Yes ☐No

Have you ever had your teeth straightened(braces)? _____ When? _____

Do you smoke? ☐ Yes ☐ NO How long? _____ How much?_____

Date of last teeth cleaning: _____ How often do you brush: _____ How often do you floss: _____

Medical History

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No
Have you ever had a serious illness or hospitalization? ☐ Yes ☐ No Describe: _____
Check (√) if you have or have ever had any of the following:

☐ Anemia	☐ Circulatory Problems	☐ Heart Murmur	☐ Pacemaker
☐ Arthritis, Rheumatism	☐ Cortisone Treatments	☐ Hemophilia	☐ Radiation Treatment
☐ Artificial Heart Valve	☐ Cough (Persistent)	☐ Hepatitis	☐ Respiratory Disease
☐ Artificial Joints	☐ Diabetes	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Back Problems	☐ Emotional Problems	☐ HIV/AIDS	☐ Shortness of Breath
☐ Blood Disease	☐ Epilepsy	☐ Kidney Disease	☐ Stroke
☐ Blood Thinning Medication	☐ Fainting	☐ Liver Disease	☐ Thyroid Problems
☐ Cancer	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Chemotherapy	☐ Heart Attack/Bypass	☐ Osteoporosis	☐ Ulcer

MEDICATIONS

List medications currently being taken: _____
_____
_____
_____

ALLERGIES

☐ Aspirin	☐ Penicillin
☐ Codeine	☐ Sulfa
☐ Latex	☐ Tetracycline
☐ Local Anesthetic	☐ Other_____

Signatures

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform the doctor if I, or my minor child, have **any** changes in health or medications taken.

×_____ _____ _____
Signature of Patient, Guardian, or Personal Representative Relationship to Patient Date

We are happy to provide the service of submitting the insurance claims on your behalf- but please remember that you and your insurance carrier have a contract, **your insurance carrier and this office do not**. By signing, you assign directly to the doctor all insurance benefits, if any, and you acknowledge that you are financially responsible for all charges whether or not paid by your insurance carrier.

×_____ _____ _____
Signature of Patient, Guardian, or Personal Representative Relationship to Patient Date

DOCTOR'S SIGNATURE: _____ **DATE:** _____