# 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.

Date_____

## Patient Information

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

Address _____ Home Phone _____ Cell Phone_____

City_____ State _____ Zip _____ Email _____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you?_____

Notify in case of emergency _____ Home Phone_____ Work Phone _____

Cell Phone_____ Business Email_____

## Primary Insurance

Person Responsible for Account _____
Last Name First Name Middle 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 _____

Contract # _____ Group # _____ Subscriber's # _____

Name(s) of other dependents under this plan _____

## Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient)_____ Soc. Sec. # _____

City _____ State _____ Zip_____ Home Phone _____

Cell Phone_____ Business Phone _____

Subscriber Employed by_____ Business Email _____

Insurance Company _____ Phone_____ Insurance Email _____

Contract # _____ Group # _____ Subscriber's # _____

Name(s) of other dependents under this plan _____

Please complete both sides.

# Dental History

Reason for today's visit _____

Are you in dental discomfort today? _____

Former Dentist _____ Address _____ Phone _____

Dentist's Email _____

Date of last dental care _____ Date of last X-rays _____

Check Y for yes or N for no if you have or have not had the following:

- ☐Y ☐N Bad breath
- ☐Y ☐N Bleeding gums
- ☐Y ☐N Clicking or popping jaw
- ☐Y ☐N Pain around ear
- ☐Y ☐N Food collection between teeth
- ☐Y ☐N Grinding or clenching teeth
- ☐Y ☐N Loose teeth or broken fillings
- ☐Y ☐N Gums swollen or tender
- ☐Y ☐N Periodontal treatment
- ☐Y ☐N Sensitivity to cold
- ☐Y ☐N Sensitivity to hot
- ☐Y ☐N Jaw pain or tiredness
- ☐Y ☐N Sensitivity to sweets
- ☐Y ☐N Sensitivity when biting
- ☐Y ☐N Sores or growths in mouth

How often do you brush? _____ How often do you 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

# Medical History

Physician's name _____ Address _____ Phone _____

Physician's Email _____ 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 _____

Have you ever taken Fen-Phen/Redux? ☐Y ☐N

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

Check Y for yes or N for no if you have or have not had any of the following:

- ☐Y ☐N AIDS/HIV Positive
- ☐Y ☐N Anaphylaxis
- ☐Y ☐N Anemia
- ☐Y ☐N Arthritis, Rheumatism
- ☐Y ☐N Artificial heart valves
- ☐Y ☐N Artificial joints
- ☐Y ☐N Asthma
- ☐Y ☐N Atropic (allergy prone)
- ☐Y ☐N Back problems
- ☐Y ☐N Blood disease
- ☐Y ☐N Blood pressure high/low
- ☐Y ☐N Cancer
- ☐Y ☐N Chemical dependency
- ☐Y ☐N Chemotherapy
- ☐Y ☐N Circulatory problems
- ☐Y ☐N Cortisone treatments
- ☐Y ☐N Cough, persistent
- ☐Y ☐N Cough up blood
- ☐Y ☐N Diabetes
- ☐Y ☐N Epilepsy
- ☐Y ☐N Fainting
- ☐Y ☐N Food allergies
- ☐Y ☐N Glaucoma
- ☐Y ☐N Headaches
- ☐Y ☐N Heart murmur
- ☐Y ☐N Heart problems
  Describe _____
- ☐Y ☐N Hemophilia/Abnormal bleeding
- ☐Y ☐N Herpes
- ☐Y ☐N Hepatitis
- ☐Y ☐N Jaw pain
- ☐Y ☐N Kidney disease or malfunction
- ☐Y ☐N Liver disease
- ☐Y ☐N Material alergies (**latex**, wool, metal, chemicals)
- ☐Y ☐N Mitral valve prolapse
- ☐Y ☐N Nervous problems
- ☐Y ☐N Pacemaker/Heart surgery
- ☐Y ☐N Psychiatric care
- ☐Y ☐N Rapid weight gain or loss
- ☐Y ☐N Radiation treatment
- ☐Y ☐N Respiratory disease
- ☐Y ☐N Rheumatic fever
- ☐Y ☐N Scarlet fever
- ☐Y ☐N Shingles
- ☐Y ☐N Shortness of breath
- ☐Y ☐N Sinus trouble
- ☐Y ☐N Skin rash
- ☐Y ☐N Spina Bifida
- ☐Y ☐N Stroke
- ☐Y ☐N Surgical implant
- ☐Y ☐N Swelling of feet or ankles
- ☐Y ☐N Thyroid disease or malfunction
- ☐Y ☐N Tobacco habit
- ☐Y ☐N Tonsillitis
- ☐Y ☐N Tuberculosis
- ☐Y ☐N Ulcer/Colitis
- ☐Y ☐N Veneral disease

**List medications you are currently taking, if any:**

_____

_____

**List drug allergies, if any:**

_____

_____

# 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 my insurance company to pay to the dentist or dental group 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 relase 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.

Signature _____ Date _____