



Welcome

TO OUR PRACTICE

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient # _____
SS # _____
Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Home Phone (____) _____
Address _____ City _____ State _____ Zip _____
Check Appropriate Box: Minor Single Married Divorced Widowed Separated
Patient's or Parent's Employer _____ Work Phone (____) _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent's Name _____ Employer _____ Work Phone (____) _____
If Patient is a Student, Name of School/College _____ City _____ State _____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency _____ Phone (____) _____

RESPONSIBLE PARTY

Name of Person _____ Relation to Patient _____
Responsible for this Account _____
Address _____ Home Phone (____) _____
Driver's License # _____ Birthdate _____ Bank _____
Employer _____ Work Phone (____) _____
Currently a Patient in our Office? Yes No

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Employer _____ Work Phone (____) _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Address _____ City _____ State _____ Zip _____
How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Employer _____ Work Phone (____) _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Address _____ City _____ State _____ Zip _____
How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

OVER

DENTAL HISTORY

Reason for today's visit _____ Date of last dental visit _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had any of the following:

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

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to a "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Have you had any serious illnesses or operations? Yes No If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check (✓) if you have had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |

Medications:

List medications you are currently taking and the correlating diagnosis: _____

Allergies:

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor 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 authorize the use of this signature on all insurance submissions.

Signature of patient or parent if minor _____

Date _____

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