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 | Phone ( )

Address | City | State | Zip

Sex [ ] M [ ] F [ ] Married [ ] Widowed [ ] Single [ ] Minor

[ ] Separated [ ] Divorced [ ] Partnered for years

E-mail | Alt. Phone #1 ( ) | Alt. Phone #2 ( )

Employer/School | Employer/School Phone ( )

Employer/School Address | City | State | Zip

Spouse or Parent's Name | Employer | Work Phone ( )

Whom may we thank for referring you?

Person to contact in case of emergency | Phone ( )

RESPONSIBLE PARTY

Name of Person Responsible for this Account | Relation to Patient

Address | Home Phone ( )

Driver's License # | Birthdate | Bank

Employer | Work Phone ( )

Currently a patient in our office? [ ] Yes [ ] No E-mail | Cell Phone ( )

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

- O V E R -

DENTAL HISTORY

Reason for today's visit ..... Date of last dental care

Former Dentist Date of last dental X-rays

Address .....

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

[ ] Bad breath	[ ] Grinding teeth	[ ] Sensitivity to hot
[ ] Bleeding gums	[ ] Loose teeth or broken fillings	[ ] Sensitivity to sweets
[ ] Clicking or popping jaw	[ ] Periodontal treatment	[ ] Sensitivity when biting
[ ] Food collection between the teeth	[ ] Sensitivity to cold	[ ] 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 used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. [ ] Yes [ ] No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? Those 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

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
[ ]	[ ]	Anemia	[ ]	[ ]	Congenital Heart Lesions	[ ]	[ ]	Hepatitis	[ ]	[ ]	Scarlet Fever
[ ]	[ ]	Arthritis, Rheumatism	[ ]	[ ]	Cortisone Treatments	[ ]	[ ]	Hernia Repair	[ ]	[ ]	Shortness of Breath
[ ]	[ ]	Artificial Heart Valves	[ ]	[ ]	Cough, Persistent	[ ]	[ ]	High Blood Pressure	[ ]	[ ]	Skin Rash
[ ]	[ ]	Artificial Joints, Pins, etc.	[ ]	[ ]	Cough up Blood	[ ]	[ ]	HIV/AIDS	[ ]	[ ]	Stroke
[ ]	[ ]	Asthma	[ ]	[ ]	Diabetes	[ ]	[ ]	Jaw Pain	[ ]	[ ]	Swelling of Foot or Ankles
[ ]	[ ]	Back Problems	[ ]	[ ]	Epilepsy	[ ]	[ ]	Kidney Disease	[ ]	[ ]	Thyroid Problems
[ ]	[ ]	Bleeding Abnormally	[ ]	[ ]	Fainting	[ ]	[ ]	Liver Disease	[ ]	[ ]	Tobacco Habit
[ ]	[ ]	Blood Disease	[ ]	[ ]	Glaucoma	[ ]	[ ]	Mitral Valve Prolapse	[ ]	[ ]	Tonsillitis
[ ]	[ ]	Cancer	[ ]	[ ]	Headaches	[ ]	[ ]	Pacemaker	[ ]	[ ]	Tuberculosis
[ ]	[ ]	Chemical Dependency	[ ]	[ ]	Heart Murmur	[ ]	[ ]	Radiation Treatment	[ ]	[ ]	Ulcer
[ ]	[ ]	Chemotherapy	[ ]	[ ]	Heart Problems	[ ]	[ ]	Respiratory Disease	[ ]	[ ]	Venereal Disease
[ ]	[ ]	Circulatory Problems	[ ]	[ ]	Hemophilia	[ ]	[ ]	Rheumatic Fever			

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

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with and assign directly to
Name of Insurance Company(ies)

Dr. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative Date

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

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