WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Cell Phone ______
Soc. Sec. # ______
Date ______

Patient Information (CONFIDENTIAL)

Name ______ Birthdate ______ Home Phone ______
Address ______ City ______ State ______ Zip Code ______
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If Student, Name of School/College ______ City ______ State ______ ☐ Full Time ☐ Part Time
Patient's or Parent's Employer ______ Work Phone ______
Business Address ______ City ______ State ______ Zip Code ______
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 ______ Relationship to Patient ______
Address ______ Home Phone ______
Birthdate ______ Employer ______ Work Phone ______
Social Security # ______ Is this Person Currently a Patient in our Office? ☐ Yes ☐ No
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
☐ Cash ☐ Personal Check Credit Card ☐ Visa ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured ______ Relationship to Patient ______
Birthdate ______ Social Security # ______ Date Employed ______
Name of Employer ______ Union or Local # ______ Work Phone ______
Address of Employer ______ City ______ State ______ Zip Code ______
Insurance Company ______ Group # ______ Policy/ID # ______
Ins. Co. Address ______ City ______ State ______ Zip Code ______
How Much is your Deductible? ______

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured ______ Relationship to Patient ______
Birthdate ______ Social Security # ______ Date Employed ______
Name of Employer ______ Union or Local # ______ Work Phone ______
Address of Employer ______ City ______ State ______ Zip Code ______
Insurance Company ______ Group # ______ Policy/ID # ______
Ins. Co. Address ______ City ______ State ______ Zip Code ______

Over Please

Dental Information

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation *Are you in pain?* ☐ No ☐ Yes *How Long?* ___________

Please check any of the following problems:

☐ Discomfort, clicking or popping in jaw	☐ Lost/Broken Filling(s)	☐ Stained teeth
☐ Red, swollen or bleeding gums	☐ Teeth grinding	☐ Locking Jaw
☐ Sensitive tooth, teeth or gums	☐ Ringing in Ears	☐ Bad breath
☐ Blisters/Sores in or around the mouth	☐ Broken/Chipped tooth	☐ Other: ___________

Do you require pre-medication? ☐ Yes ☐ No ☐ Don't know

Previous Dentist: ___________ *Phone* ___________

Last Dental Exam: ___________ *Last Dental X-rays:* ___________

Times a day you brush? _______ *Times a week you floss?* _______ *What type of tooth brush bristles do you use?* ☐ Soft ☐ Medium ☐ Hard

How would you rate your smile? 1 2 3 4 5 6 7 8 9 10

Medical History

Are you taking any of the following medications?

	Yes	No		Yes	No		Yes	No
Nerve pills	☐	☐	Stimulants	☐	☐	Insulin	☐	☐
Pain killers (including aspirin)	☐	☐	Blood Thinners	☐	☐	Other(s) ___________	☐	☐
Muscle relaxers	☐	☐	Tranquilizers	☐	☐	___________	☐	☐

Do you have or ever had any of the following diseases or medical conditions?

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Attack / Stroke	☐	☐	Kidney Problems	☐	☐	Cancer/Tumors	☐	☐	Chemotherapy	☐	☐
Heart Surg./Pacemaker	☐	☐	Liver Problems	☐	☐	Shingles	☐	☐	Asthma	☐	☐
Heart Murmur	☐	☐	Respiratory Problems	☐	☐	Hepatitis	☐	☐	Difficulty Breathing	☐	☐
Rheumatic Fever	☐	☐	Sinus Problems	☐	☐	HIV+/AIDS/ARC	☐	☐	Diabetes/Hypoglycemia	☐	☐
Mitral Valve Prolapse	☐	☐	Stomach Problems/Ulcers	☐	☐	Arthritis/Rheumatism	☐	☐	Leukemia	☐	☐
Artificial Valves	☐	☐	Psychiatric Problems	☐	☐	Artificial Bones/Joints	☐	☐	Anemia	☐	☐
Heart Disease	☐	☐	Venereal Disease	☐	☐	Emphysema	☐	☐	High/Low Blood Pressure	☐	☐
Congenital Heart Defect	☐	☐	Alcohol/Drug Abuse	☐	☐	Fainting/Seizures/Epilepsy	☐	☐	Bleeding Problems	☐	☐
Chest Pains	☐	☐	Tuberculosis TB	☐	☐	Severe/Frequent Headaches	☐	☐	Glaucoma	☐	☐
Scarlet Fever	☐	☐	Jaw Problems TMJ/TMD	☐	☐	Frequent Neck Pain	☐	☐	Back Problems	☐	☐

Please list any other medical condition(s) you have or ever had: ___________

Are you allergic to any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
Latex	☐	☐	Tetracycline	☐	☐	Dental Anesthetics	☐	☐	Others: ______	☐	☐
Penicillin/Amoxicillin	☐	☐	Aspirin	☐	☐	Others: ______	☐	☐	Others: ______	☐	☐

Do you use tobacco? ☐ No ☐ Yes/How used? ___________ *How much?* ___________ *How long?* ___________

Please rate your general health from 1-10: ___________ *Do you wear contact lenses?* ☐ Yes ☐ No

Have you ever taken the drug Phen-fen and/or Redux? ☐ Yes ☐ No

For women: *Are you taking Birth Control pills?* ☐ Yes ☐ No *Are you Pregnant?* ☐ No ☐ Yes/How long? ______ *Are you nursing?* ☐ Yes ☐ No

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature ___________________________ Date ___________

☐ Adult Patient ☐ Parent or Guardian ☐ Spouse

UPDATE (Office Use)

Initials	Date	Initials	Date	Initials	Date

Comments	Comments	Comments