

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.

Patient Information (Confidential)

Date _____

Name _____ Birthdate _____ Soc.Sec.# _____

Address _____

City _____ State _____ ZIP _____ Home Phone# _____

Check Appropriate Box: Married Single Divorced Widowed Separated Minor

If Student, Name of School /College _____ City/State _____ Full Part

Patient's or Parent's Employer _____ Work Phone# _____

Business Address _____ City/State _____ ZIP _____

Spouse or Parent's Name _____ Employer _____ Work Phone# _____

Whom May We Thank You for Referring You? _____

Person to Contact in Case of Emergency _____ Phone# _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship _____

Address _____ Home Phone# _____

Driver's L# _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone# _____ Soc.Sec.# _____

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.

Our office policy is that we collect your portion at the time of service. Cash Personal Check

Credit Card VISA Mastercard American Express Discover

Insurance Information

Name of Insured _____ Relationship _____

Birthdate _____ Soc.Sec# _____ Date Employed _____

Name of Employer _____ Union/Local# _____ Work Phone# _____

Address of Employer _____ City/State _____ ZIP _____

Insurance Company _____ Group# _____ Policy/ID# _____

Ins.Co.Address _____ City/State _____ ZIP _____

How Much is your Deductible? _____ How Much Have You Used? _____ Annual Max. _____

Do you have ADDITIONAL INSURANCE? Yes No If yes, please complete the following:

Name of Insured _____ Relationship _____

Birthdate _____ Soc.Sec# _____ Date Employed _____

Name of Employer _____ Union/Local# _____ Work Phone# _____

Address of Employer _____ City/State _____ ZIP _____

Insurance Company _____ Group# _____ Policy/ID# _____

Ins.Co.Address _____ City/State _____ ZIP _____

How Much is your Deductible? _____ How Much Have You Used? _____ Annual Max. _____

Patient Medical History

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

	Yes	No		Yes	No
1. Are you in good health?.....	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you bruise easily?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have there been any changes in your general health within the last year?.....	<input type="checkbox"/>	<input type="checkbox"/>	10. Have you ever required a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>
3. Date of your last physical exam _____			11. Have you had a recent weight loss?.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Physician's Name _____			12. Have you ever taken Fen-Phen or Redux?...	<input type="checkbox"/>	<input type="checkbox"/>
Address _____			13. Do you use tobacco?.....	<input type="checkbox"/>	<input type="checkbox"/>
Phone # _____			14. Do you or have you used controlled substances?.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you now under the care of a physician?... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Are you wearing contact lenses?.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever been hospitalized for any surgical operation or serious illness?..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you have any other disease, condition, or problem not listed above that you think we should know about?..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please explain: _____					
7. Are you taking any medicine(s) including non-prescription medicine?..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Women Only:		
If yes, what medicine(s) are you taking? _____			Are you pregnant or think you may be pregnant?..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you had any abnormal bleeding?..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing?..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Are you taking birth control pills?..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No		Yes	No		Yes	No
Are you allergic to or have you had reactions to?:			Joint replacement or implant..	<input type="checkbox"/>	<input type="checkbox"/>	Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>
Local anesthetic like Novocaine <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis or rheumatism.....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or dizzy spells.....	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath.....	<input type="checkbox"/>	<input type="checkbox"/>	Stomach ulcer.....	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or			Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney trouble.....	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping pills..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High/Low Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough.....	<input type="checkbox"/>	<input type="checkbox"/>
Iodine..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Congenital heart problem.....	<input type="checkbox"/>	<input type="checkbox"/>	Cough that produces blood.....	<input type="checkbox"/>	<input type="checkbox"/>
Any metals (e.g., Nickel,			Swelling of feet, ankles, hands	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy (Cancer,		
Mercury, etc.)..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, Jaundice, or			Leukemia)..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Latex rubber..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Tumors..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other(Please list) _____			Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or seizures.....	<input type="checkbox"/>	<input type="checkbox"/>
			Sinus trouble.....	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or have you ever had the following?:			Lung or breath problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Care.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Heart Disease or			Asthma or hay fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Back Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hives or skin rash.....	<input type="checkbox"/>	<input type="checkbox"/>	Chemical Dependency.....	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart defect or heart murmur <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease...	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Treatment.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart trouble, heart attack,			AIDS or HIV infection.....	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores/Fever Blisters.....	<input type="checkbox"/>	<input type="checkbox"/>
or angina..... <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia.....	<input type="checkbox"/>	<input type="checkbox"/>
			Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorders.....	<input type="checkbox"/>	<input type="checkbox"/>
			Tonsillitis.....	<input type="checkbox"/>	<input type="checkbox"/>			

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to the third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. If I become delinquent and my account is referred for collection, I agree to pay all costs for collection, including, but not limited to collection fees, court costs, and interest charges.

Signature of Patient (or parent if minor)

Date