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
1. Are you in good health?	☐	☐
2. Have there been any changes in your general health within the last year?	☐	☐
3. Date of your last physical exam_____		
4. Physician's Name_____ Address_____ Phone #_____		
5. Are you now under the care of a physician?	☐	☐
6. Have you ever been hospitalized for any surgical operation or serious illness? Please explain:_____	☐	☐
7. Are you taking any medicine(s) including non-prescription medicine? If yes, what medicine(s) are you taking?_____	☐	☐
8. Have you had any abnormal bleeding?	☐	☐
9. Do you bruise easily?	☐	☐
10. Have you ever required a blood transfusion?	☐	☐
11. Have you had a recent weight loss?	☐	☐
12. Have you ever taken Fen-Phen or Redux?	☐	☐
13. Do you use tobacco?	☐	☐
14. Do you or have you used controlled substances?	☐	☐
15. Are you wearing contact lenses?	☐	☐
16. Do you have any other disease, condition, or problem not listed above that you think we should know about?	☐	☐
Women Only:		
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking birth control pills?	☐	☐

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

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*