

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ SSN _____
Last Name First Name Initials

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex M F Age _____ Birthdate _____ Marital Status _____

Patient Employed by _____ Occupation _____

Business Address _____

Business Phone _____ Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____

Home Phone _____ Cell Phone _____

Business Phone _____ Email _____

Primary Insurance

Name _____ SSN _____
Last Name First Name Initials

Relationship to Patient _____ Birthday _____ SSN _____

Address (if different from patient) _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Employed by _____ Occupation _____

Business Address _____

Business Phone _____ Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber _____

Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Relation to patient _____ Birthday _____

Address (if different from patient) _____ SSN _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Employed by _____ Occupation _____

Business Address _____

Business Phone _____ Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber _____

Name of other dependents under this plan _____

Dental History

What would you like us to do today? _____ Are you in dental discomfort today? Y N

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check yes or no if you have had problems with any of the following:

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

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Y N

Other information about your dental health or previous treatment _____

Medical History

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? Y N

If yes, describe _____

Are you currently under physician care? Y N If yes, describe _____

Have you ever had a blood transfusion? Y N If yes, approx.. date. _____

Have you ever taken Fen-Phen/Redux? Y N

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. Y N

Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Check if you have had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Cough, persistent | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Food allergies | <input type="checkbox"/> Material allergies (latex, wool, metal, chemicals) | <input type="checkbox"/> Surgical implant |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Swelling of feet or ankles |
| <input type="checkbox"/> Atopic (allergy prone) | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous problems | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Pacemaker/Heart surgery | <input type="checkbox"/> Tobacco habit |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer | Describe _____ | <input type="checkbox"/> Rapid weight gain or loss | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Hemophilia/ Abnormal bleeding | <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Herpes | <input type="checkbox"/> Respiratory disease | |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Ulcer/Colitis | <input type="checkbox"/> Rheumatic/Scarlet fever | |
| <input type="checkbox"/> Cortisone treatments | | | |

Is patient currently taking any medications? If yes, list all: _____ Does patient have drug allergies? If yes, list all: _____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist 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.

Signature _____

Date _____

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