WELCOME TO OUR PRACTICE

DATE:________________________

Patient Information

First: ____ Middle ______ Last:____

Street: ______________________________________ Apt. #_______ City: ____________________________ State: _____ Zip: ________

Home Phone: ____ Work Phone: ____

Cell Phone: ____ Driver's License #:____

Patient Social Security #: ____________________________________ Patient Date of Birth: __________________________ Sex: M F

__Married __Single __Widowed __Separated __Divorced Email: ____

Employer: ____ Occupation: ____

Employer's Address: ____ City: ___________________________ State: _____ Zip: ________

Emergency Contact: ____ Phone: ___________________________________

If Student, name of School/College: ____________________________________ City: ___________________________________ State: _____

How did you hear about us?

- ☐ Insurance Provider
- ☐ Internet
- ☐ Television
- ☐ Community Event
- ☐ Radio
- ☐ Other
- ☐ Mailing
- ☐ Referral
- ☐ Social Media
- ☐ Online Review

____ (Patient Name)

If the person responsible for this patient's account is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section titled "Insurance Information".

Name of responsible party: ____ Relationship to Patient: ____________________________

Mailing Address: ____ City: ___________________________ State: _____ Zip: ________

Sex: M F Age: _____ Birth Date: ___________ Single Married Widowed Separated Divorced SS#: ______________________

Home Phone: ____ Work Phone: ____

Occupation: ____ Employer: ____

Employer's Address: ______________________________________ City: ______________________________ State: _____ Zip: _________

Insurance Information

Primary Dental Insurance

Policy Holder's Name: __________________________ Relationship to Patient: ______________ SS#: ___________________ DOB:_________

Employer: ____ Employer's Address: ____________________________________ State: _____

Insurance Co: ____ Group #: ________________ Member ID #:_________________

Insurance Address: ____

Secondary Dental Insurance

Policy Holder's Name: __________________________ Relationship to Patient: ______________ SS#: ___________________ DOB:_________

Employer: ____ Employer's Address: ____________________________________ State: _____

Insurance Co: ____ Group #: ________________ Member ID #:_________________

Insurance Address: ____

HEALTH HISTORY

Answers to the following questions are for our records only and will be considered confidential.

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

Heart Disease or Attack	Yes	No	Shortness of Breath	Yes	No	Alcoholism	Yes	No
Angina Pectoris	Yes	No	Ulcers	Yes	No	Herpes	Yes	No
Heart Problems	Yes	No	Intellectual Disability	Yes	No	Glaucoma	Yes	No
Liver Disease	Yes	No	Emphysema	Yes	No	*Steroid Treatment	Yes	No
High Blood Pressure	Yes	No	Fainting or Dizzy Spells	Yes	No	Arthritis	Yes	No
*Heart Murmur	Yes	No	Epilepsy or Seizures	Yes	No	Birth Defects	Yes	No
*Rheumatic Fever	Yes	No	Persistent Cough	Yes	No	HIV Positive, ARC, AIDS	Yes	No
Psychiatric Treatment	Yes	No	Tuberculosis (TB)	Yes	No	Hay Fever	Yes	No
Sickle Cell Disease	Yes	No	Asthma	Yes	No	Use of Tobacco Products	Yes	No
Sinus Trouble	Yes	No	*Congenital Heart Problems	Yes	No	Bruise Easily	Yes	No
*Artificial Joints	Yes	No	Hepatitis A (Infectious)	Yes	No	Jaundice	Yes	No
Thyroid Disease	Yes	No	Hepatitis B (Serum)	Yes	No	Kidney Trouble	Yes	No
Anemia	Yes	No	Hepatitis C or Other	Yes	No	Human Papilloma Virus/HPV	Yes	No
Blood Transfusion	Yes	No	Heart Pacemaker	Yes	No	Hemophilia	Yes	No
*Any Type of Transplant	Yes	No	Stroke	Yes	No	Diabetes __Type I __Type II	Yes	No
*Mitral Valve Prolapse	Yes	No	Drug Addiction	Yes	No	Chemotherapy/Radiation	Yes	No
Hives or Skin Rash	Yes	No	Cold Sores	Yes	No	Cancer, type:____________________	Yes	No
Scarlet Fever	Yes	No	COPD (Chronic Obstructive Pulmonary Disorder)	Yes	No	MRSA	Yes	No

***Antibiotic pre-medication may be required prior to your appointment.**

ALLERGIES

Aspirin	Local Anesthetic	None
Barbituates	Penicillin
Codeine	Sulfa
Iodine	Metals
Latex	Other: _________________

MEDICATIONS

Please list medications you are currently taking:
____
____
____
____
Pharmacy: ______________________________

Do you have existing dentures Yes No How old is denture ________ Upper/Lower
Do you have existing partials Yes No How old is partial ________ Upper/Lower

1. Have you or any member of your family been seen by us before? Yes No
   If yes, which family member(s)? ____

2. Date of last physical examination: ____________________ Physician's name: ________________________________

3. Previous dentist's name: ___________________________ Date of last dental x-rays: ________________________________

4. Are you having pain or discomfort at this time? Yes No

5. Do you clench or grind your teeth? Yes No

6. Do you have any sores, lumps or growths in or near your mouth? Yes No

7. Have you ever had any excessive bleeding requiring special treatment? Yes No

8. Have you ever needed to see a periodontist? Yes No

9. Is there anything you would like to change about the way your smile looks? ☐ straighter ☐ whiter

10. Do you currently have any of the following? ☐ swelling ☐ bleeding gums ☐ loose teeth ☐ bad breath

11. Have you experienced any reactions to treatment in your previous visits to the Dentist? Yes No
    If yes, please explain: ____

12. Is there anything related to your medical or dental history that you have not indicated above? Yes No
    If yes, please explain: ____

WOMEN: Are you pregnant now? Yes No If yes, what is your due date? ____________________
Are you currently breast feeding? Yes No
Are you taking oral contraceptives? Yes No

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 third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand 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.

X______________________________ ______________________________ ______________________
Signature of Patient or Parent/Guardian	Print Name	Date

X______________________________ ______________________
Doctor Signature	Date