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 _____ _____ _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Add _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ☐M ☐F Age _____ Birthdate _____ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

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 Phon _____

Emai _____

Primary Insurance

Person Responsible for Account _____ _____ _____
Last Name *First Name* *Initial*

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____ Home Phon _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Mailing Address _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Pharmacy Nar _____ Phon _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Mailing Address _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Please complete both sides.

Dental History

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

Former Dentis Address

Dentist's Email Phone

Date of last dental care Date of last x-

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

Y N Bad breath
Y N Bleeding gums
Y N Clicking or popping jaw
Y N Food collection between teeth
Y N Grinding or clenching teeth
Y N Loose teeth or broken fillings
Y N Periodontal treatment
Y N Sensitivity to cold
Y N Sensitivity to hot
Y N Sensitivity to sweets
Y N Sensitivity when biting
Y N Sores or growths in mouth

How often do you brush? Floss?

How do you feel about the appearance of your te

Do you wish your teeth were straighter? Y N

Do you wish your teeth were whiter? Y N

Are you unhappy with any fillings, crowns or bridges? Y N

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, give approximate d

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

Do you smoke or use other tobacco/smokeless products? Y N Please circle all that apply: Cigarettes Cigars Vape Marijuana Chew Other

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

Check (✓) yes or no whether you have had any of the following:

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

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.

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