WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out our paperwork as completely as you can. If you have questions, we will 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 Middle Initial

Address:_____City:_____State:____Zip:_____

Cell phone: _____Email:_____

Sex: ☐M ☐F Age:_____ Birthdate:_____ ☐ Single ☐Married ☐Widowed ☐Other

Patient Employer:_____

Occupation_____ Business Phone:_____

Whom may we thank for referring you?_____

Notify in case of Emergency:_____Home Phone:_____

Cell Phone:_____Business Phone:_____

Email:_____

Person Responsible for Account: _____
Last Name First Name Middle Initial

PRIMARY INSURANCE

Subscriber Name:_____ Birthdate:_____
Last Name First Name Middle Initial

Subscriber Employed by: _____Insurance Company:_____

Group #_____Subscriber ID#_____

Name of other dependents under this plan, and relation to Subscriber_____

_____ _____ _____

SECONDARY INSURANCE

Subscriber Name:_____ Birthdate:_____
Last Name *First Name* *Middle Initial*

Subscriber Employed by: _____Insurance Company:_____

Group #_____Subscriber ID#_____

Name of other dependents under this plan, and relation to Subscriber_____

_____ _____ _____

DENTAL HISTORY

What would you like us to do today?_____

Former Dentist:_____Address:_____

Dentist's Email:_____Phone:_____Fax:_____

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

MEDICAL HISTORY

Physician's Name: _____Phone:_____

Date of last visit:_____Have you had any serious Illnesses or operations?

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 dates:_____

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

Are you pregnant? ☐ Y ☐ N Nursing ☐ Y ☐ N Taking birth control pills ☐ Y ☐ N

Mark (**X**) if you *have* or *have had* any of the following:

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

Are you currently taking any medications? If yes, list all:_____
_____
_____
_____

Do you have any 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_____