WELCOME

We would like to welcome you to the office! Please take a few minutes to fill out this form as completely as you can. If you have any questions we will be glad to help.

PATIENT INFORMATION

Name____ **Soc. Sec.#**____________________
Last Name First Name Initial
Physical Address (REQUIRED)____
City______________________ **State**_________ **Zip**____________ **Home Phone**________________
Mailing Address (If different from above)____
Cell Phone_____________________ **Patient E-Mail** ______________________________
Sex ☐ **M** ☐ **F** **Age**_______ **Birthday**__________ ☐ **Child** ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Other**
Patient Employed by_________________________________ **Occupation**__________________
Business Address____________________________________ **Business Phone** ______________
Emergency Contact (not living with you)_____________________________ **Phone**________________
Cell Phone____________________________ **Business Phone**____________________________
Whom may we thank for referring you? ____

PRIMARY INSURANCE

(Complete this Section if different from above)

Person Responsible for Account____
Last Name First Name Initial
Relation to Patient______________________ **Birthday**_______________ **Soc Sec#** ________________
Address ____
City_________________ **State**___________ **Zip**______________ **Home Phone**________________
Cell Phone____________________________ **E-Mail** __________________________________
Person Responsible Employed by______________________________ **Occupation** _____________
Business Address____ **Business Phone** ____________
Insurance company_______________________________________ **Phone** __________________
Group#______________________________ **Subscriber ID**_____________________________
Name of other dependents under this plan____

ADDITIONAL INSURANCE

(Complete this section if different from above)

Is patient covered by additional insurance? ☐ **YES** ☐ **NO**
Subscriber Name__________________________ **Birthday**____________ **Relation to Patient**___________
Address____ **Soc. Sec#**__________________
City______________________ **State**________ **Zip**______________ **Home Phone**________________
Cell Phone_______________________________________ **E-Mail**_________________________________
Subscriber Employed by____ **Business Phone**_____________
Insurance Company____ **Phone**____________________
Group#____________________________________ **Subscriber ID**_____________________________
Name of other dependents under this plan____

DENTAL HISTORY

What would you like us to do today___________________________ Are you in dental discomfort today?________
Former Dentist______________________________ Phone Number____
Date of last dental care______________________________ Date of last X-rays______________________________
Check if you have had problems with any of the following:

________ Bad Breath	________Food Collection between teeth	________Periodontal Treatment	________Sensitivity to Sweets
________ Bleeding gums	________Grinding or clenching teeth	________Sensitivity to cold	________Sensitivity when biting
______ Clicking or popping jaw	______Loose teeth or broken fillings	_______Sensitivity to hot	______Sore or growths in mouth

How often do you brush_______________________________________ Floss?______________________________
How do you feel about the appearance of your teeth?____
Have you ever experienced an adverse reaction during on in conjunction with a medical or dental procedure? ____
Other information about your dental health or pervious 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 dates____________________
Women: Are you pregnant? ☐ Y ☐ N Nursing? ☐ Y ☐ N Taking birth control? ☐ Y ☐ N
Have you ever taken Fen-Phen/Redux? ☐ Y ☐ N
Check if you have any of the following:

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

Is the patient currently on any Bisphosponate, such as (Foasamax, Actonel, Boniva, Areidia, Bonefos, Didronel, or Zometa)?
____

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 from to pay to the dentist all insurance benefits otherwise payable to me for service 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 where or not paid by insurance.

Signature____ Date___________________