WELCOME TO OUR PRACTICE!

Name_____Soc. Sec. _____
Last Name *First Name* *M.I.*

Address_____

City _____State_____Zip_____Home Phone_____

Cell Phone_____ Email_____

I prefer to receive appointment confirmations via □ Phone □ Email □ Text Message

Sex □ M □ F Birthdate_____ □ Single □ Married □ Widowed □ Separated □ Divorced

Patient Employed by_____Occupation_____

Business Address_____ Phone _____

Whom may we thank for referring you?_____

Notify in case of emergency_____Relation to Patient_____

Home Phone_____ Cell Phone_____

Primary Insurance

Person Responsible for Account_____

Relation to Patient_____Birthdate_____Soc. Sec. #_____

Address (if different from patient)_____

City_____State_____Zip_____ Home Phone_____

Cell Phone_____Email_____

Employer Name_____ Business Phone_____

Insurance Company_____ ID #_____

Other dependants on this plan_____

Dental History

What would you like us to do today?_____Are you in discomfort?_____

Former Dentist_____ Phone_____

Have you had x-rays taken in the last year? _____ Date of last dental visit _____

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

□ Y □ N Bad Breath
□ Y □ N Sensitivity to sweets
□ Y □ N Sensitivity to hot/cold
□ Y □ N Food collection between teeth
□ Y □ N Bleeding gums
□ Y □ N Sensitivity when biting
□ Y □ N Periodontal treatment
□ Y □ N Grinding or clenching teeth
□ Y □ N Loose Teeth or Broken Fillings

Medical History

Are you currently under physician care? □ Y □ N If yes, please describe_____

Physician's Name_____ Phone_____

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

Check yes of no whether you have had any of the following:

□ Y □ N AIDS/HIV positive
□ Y □ N Anemia
□ Y □ N Arthritis
□ Y □ N Artificial heart valves
□ Y □ N Artificial joints
□ Y □ N Asthma
□ 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 Heart Murmur
□ Y □ N Heart Problems
Describe_____
□ 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 Swelling of feet ankles
□ Y □ N Thyroid disease
□ Y □ N Tobacco Habit
□ Y □ N Tonsillitis
□ Y □ N Tuberculosis
□ Y □ N Ulcer/Colitis
□ Y □ N Venereal disease
□ Y □ N Hemophilia
□ Y □ N Herpes
□ Y □ N Hepatitis
□ Y □ N High Blood Pressure
□ Y □ N Kidney Disease
□ Y □ N Liver disease
□ Y □ N Mitral Valve Prolapse
□ Y □ N Nervous problems
□ Y □ N Pacemaker
□ Y □ N Psychiatric Care

Please list any and all medications_____ Please list all allergies_____

_____ _____

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_____