

Please take a few minutes to answer the following questions.  
This information will be considered **CONFIDENTIAL**.

**PATIENT INFORMATION**

Date \_\_\_\_\_ Soc Sec # \_\_\_\_\_ Birthdate \_\_\_\_\_  
Name (last, first, initial) \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Sex  M  F     Minor  Single  Married  Divorced  Widowed  Separated  
Employer \_\_\_\_\_ Business Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Email \_\_\_\_\_  
Occupation \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
In case of emergency, whom should we contact? \_\_\_\_\_ Phone \_\_\_\_\_

**PRIMARY DENTAL INSURANCE**

Person responsible for account (last, first, initial) \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc Sec # \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Responsible Party Employed by \_\_\_\_\_ Business Phone \_\_\_\_\_  
Business Address \_\_\_\_\_ Occupation \_\_\_\_\_  
Insurance company \_\_\_\_\_  
Insurance company address \_\_\_\_\_  
Subscriber I.D. \_\_\_\_\_ Group # \_\_\_\_\_

**ADDITIONAL INSURANCE**

Insured name (last, first, initial) \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc Sec # \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insured Employed by \_\_\_\_\_ Business Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_  
Subscriber I.D. \_\_\_\_\_ Group # \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I hereby authorize payment directly to Dr. \_\_\_\_\_ for all insurance benefits otherwise payable to me for services rendered. I understand I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

**DENTAL HISTORY**

Former Dentist \_\_\_\_\_ Date of last x-rays \_\_\_\_\_

City, State \_\_\_\_\_ How often do you floss? \_\_\_\_\_

Date of last dental visit \_\_\_\_\_ How often do you brush? \_\_\_\_\_

**Please check all that apply:**

- Bad breath
- Bleeding gums
- Blisters on lips or mouth
- Finger nail biting
- Grinding teeth
- Lip or cheek biting
- Loose teeth or broken fillings
- Orthodontic treatment
- Pain around ear
- Periodontal treatment
- Sensitivity to cold
- Sensitivity to heat
- Sensitivity to sweets
- Sensitivity when biting
- Frequent headaches
- Jaw, head or neck injuries
- Jaw difficulty: clicking &/or pain
- Tooth pain

**MEDICAL HISTORY**

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

1. Are you currently under medical treatment?  Yes  No
2. Have you ever had any serious illnesses or operations?  Yes  No
3. Are you currently taking any medication?  Yes  No If yes, please describe:
4. Do you smoke?  Yes  No
5. Do you use alcohol?  Yes  No
6. Do you wear contact lenses?  Yes  No
7. Have you had any allergic reactions to the following:

- Local Anesthetic (e.g. novocaine)  Yes  No
- Sulfa Drugs  Yes  No
- Sedatives  Yes  No
- Aspirin  Yes  No
- Penicillin or other Antibiotics  Yes  No
- Barbituates (e.g. sleeping pills)  Yes  No
- Iodine  Yes  No
- Other  Yes  No \_\_\_\_\_

8. (Women only) Are you:

Pregnant?  Yes  No      Nursing?  Yes  No      Taking birth control pills?  Yes  No

**Please check all that apply:**

- AIDS
- Anemia
- Arthritis, Rheumatism
- Artificial Heart Valve
- Artificial Joints
- Asthma
- Back Problems
- Bleeding abnormally, with extractions or surgery
- Blood Disease
- Cancer
- Chemical Dependency
- Chemotherapy
- Circulatory Problems
- Congenital Heart Lesions
- Cortisone Treatments
- Cough – persistent or bloody
- Diabetes
- Emphysema
- Epilepsy
- Fainting or Dizziness
- Glaucoma
- Headaches
- Heart Murmur
- Heart Problems
- Hepatitis – type\_\_\_\_
- Herpes
- High Blood Pressure
- HIV Positive
- Jaundice
- Jaw Pain
- Kidney Disease
- Liver Disease
- Low Blood Pressure
- Mitral Valve Prolapse
- Nervous Problems
- Pacemaker
- Psychiatric Care
- Radiation Treatment
- Respiratory Disease
- Rheumatic Fever
- Scarlet Fever
- Shortness of Breath
- Sinus Trouble
- Skin Rash
- Stroke
- Swelling of Feet/Ankles
- Swollen Neck Glands
- Thyroid Problem
- Tonsillitis
- Tuberculosis
- Tumor or growth on head/neck
- Ulcer
- Venereal Disease

**CONSENT FOR TREATMENT**

The above health history is complete and correct to the best of my knowledge. I authorize and give consent to perform dental services agreed between Doctor and Patient and/or Guardian to be necessary or advisable, including the use of local anesthesia and other medication as indicated. I agree that, regardless of insurance coverage, I am responsible for payment of services rendered and that a finance charge of 1 ½% will be applied to accounts past 60 days.

**Method for Resolving Discomfort:** All parties desire a method for resolving discomfort, misunderstandings or disputes, if any should occur – privately, quickly, economically and in a friendly, educational manner. We therefore agree to resolve these matters using the communication, negotiation, mediation and arbitration procedures set forth in the latest edition of the *LawForms Integrity Agreement*. You may receive a copy of this standard form and information about it from our office. Unless we hear from you to the contrary, we shall assume that you are familiar with the *LawForms Integrity Agreement* or have taken the time to review and understand it. You have the right to consult with an attorney and to ask questions of anyone in this office regarding the meaning of this form.

Signature \_\_\_\_\_ Date \_\_\_\_\_

(Patient, Parent or Guardian)