Welcome 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

Date_____

Name_____ Driver License#_____ Soc. Sec. # _____-_____-_____
Last Name First Name Initial

Home Phone (___) _____-_____ Cell (___) _____-_____ Email address:_____

Preferred method of contact: _____ cell _____ Home Phone _____ work _____email

Address_____ City_____ State _____ Zip _____

Gender __M __F Age_____ Birth date_____ Single____ Married ____ Widowed ____ Separated_____ Divorced____

Patient Employed by_____ Occupation_____

Business Address_____ Business Phone (___)_____-_____

Whom may we thank for referring you/ How did you hear about us?_____

In case of emergency who should be notified?_____ Phone (___)_____-_____

Responsible Party / Primary Dental Insurance

Name_____ Driver License#_____
Last Name First Name Initial

Relation to Patient_____ Birth date_____ Soc. Sec. # _____-_____-_____

Address (if different from patient's)_____ Phone (___) _____-_____

City_____ State _____ Zip _____

Subscriber Employed by_____ Occupation_____

Business Address_____ Business Phone (___)_____-_____

Insurance Company_____ Group#_____ Subscriber #_____

Names of other dependents covered under this plan_____

Secondary Dental Insurance

Is patient covered by additional dental insurance? ____ Yes ____ No

Subscriber Name_____ Birth date_____ Soc. Sec. # _____-_____-_____

Relation to Patient _____ Phone (___) _____-_____

Address (if different from patient's)_____ City _____State _____ Zip _____

Subscriber Employed by_____ Business Phone (___)_____-_____

Insurance Company_____ Group#_____ Subscriber #_____

Names of other dependents covered under this plan_____

Please Complete Both Sides

Dental History

Reason for today's visit_____ Date of last dental care_____

Former Dentist_____ Date of last dental x-rays_____

Check (√) if you have had problems with any of the following:

☐ Bad Breath	☐ Grinding Teeth	☐ Sensitivity to hot
☐ Bleeding Gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaws	☐ Periodontal treatment	☐ Sensitivity to biting
☐ Food collection between teeth	☐ Sensitivity to cold	☐ Sores or growths in your mouth

How often do you floss?_____ How often do you brush?_____

Medical History

Physician's Name_____ Date of last visit_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux . ____ Yes ____ No

Have you ever taken Fosamax, Boniva, Actonel or any medication containing bisphosphonates? _____Yes _____ No

Have you had any serious illnesses or operations? ____ Yes _____ No If yes, describe _____

Have you ever had a blood transfusion? _____ Yes _____ No If yes, give approximate dates_____

List all medications that you are taking_____

(Women only) Are you pregnant? _____ Yes _____ No Nursing? _____ Yes _____ No Taking birth control? _____ Yes _____ No

Please (√) if you are allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other_____

PLEASE CIRCLE EITHER YES (Y) or NO (N) if you now have or have had any of the following:

Y	N	Anemia	Y	N	Cortisone Treatments	Y	N	Hepatitis	Y	N	Scarlet Fever
Y	N	Arthritis, Rheumatism	Y	N	Cough, Persistent	Y	N	High Blood Pressure	Y	N	Shortness of breath
Y	N	Artificial HeartValves*	Y	N	Cough up blood	Y	N	HIV/AIDS	Y	N	Skin Rash
Y	N	Artificial Joints*	Y	N	Diabetes	Y	N	Jaw Pain	Y	N	Stroke
Y	N	Asthma	Y	N	Epilepsy	Y	N	Kidney Disease	Y	N	Swelling of feet/ankles
Y	N	Back Problems	Y	N	Fainting	Y	N	Liver Disease	Y	N	Thyroid Problems
Y	N	Blood Disease	Y	N	Glaucoma	Y	N	Osteoporosis	Y	N	Tobacco Habit
Y	N	Cancer	Y	N	Gastric Ulcer	Y	N	Pacemaker	Y	N	Tonsillitis
Y	N	Chemical Dependency	Y	N	Headaches	Y	N	Radiation Treatment	Y	N	Tuberculosis
Y	N	Chemotherapy	Y	N	Heart Attack/Problems	Y	N	Respiratory Disease	Y	N	Excessive Urination
Y	N	Circulatory Problems	Y	N	Hemophilia	Y	N	Rheumatic Fever*	Y	N	Venereal Disease

*Conditions may require medication. REVIEWED BY:_____ Date:_____

Authorization

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize my insurance company 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.

Signature_____ Date_____

Payment is due in full at time of treatment unless prior arrangements have been approved.