

# Welcome!

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

## Patient Information

Date \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_  
Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Last Name First Name Initial  
Address \_\_\_\_\_ Cell Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ E-mail \_\_\_\_\_  
Sex:  M  F  Minor  Single  Married  Long Term Partner  Divorced  Widowed  Separated  
Employer \_\_\_\_\_ Business Phone \_\_\_\_\_  
Business Address \_\_\_\_\_ Occupation \_\_\_\_\_  
Who should we thank for referring you? \_\_\_\_\_  
In case of emergency, who should we contact? \_\_\_\_\_ Phone \_\_\_\_\_

## Primary Insurance

Person Responsible for Account \_\_\_\_\_  
Last Name First Name 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 Name First Name 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 # \_\_\_\_\_

# 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 ..... <input type="checkbox"/>                | Loose Teeth or Broken Fillings ..... <input type="checkbox"/> | Sensitivity to Sweets ..... <input type="checkbox"/>            |
| Bleeding Gums ..... <input type="checkbox"/>             | Orthodontic Treatment ..... <input type="checkbox"/>          | Sensitivity When Biting ..... <input type="checkbox"/>          |
| Blisters on Lips or Mouth ..... <input type="checkbox"/> | Pain Around Ear ..... <input type="checkbox"/>                | Frequent Headaches ..... <input type="checkbox"/>               |
| Finger Nail Biting ..... <input type="checkbox"/>        | Periodontal Treatment ..... <input type="checkbox"/>          | Jaw, Head or Neck Injuries ..... <input type="checkbox"/>       |
| Grinding Teeth ..... <input type="checkbox"/>            | Sensitivity to Cold ..... <input type="checkbox"/>            | Jaw Difficulty: Clicking and/or Pain.. <input type="checkbox"/> |
| Lip or Cheek Biting ..... <input type="checkbox"/>       | Sensitivity to Heat ..... <input type="checkbox"/>            | Tooth Pain ..... <input type="checkbox"/>                       |

# Medical History

Physician's Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

- |   |                          |                          |
|---|--------------------------|--------------------------|
|   | Yes                      | No                       |
| 1. Are you currently under medical treatment? ..... | <input type="checkbox"/> | <input type="checkbox"/> |

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 2. Have you ever had any serious illnesses or operations? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 3. Are you currently taking any medication? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|

Please describe: \_\_\_\_\_

- |                        |                          |                          |
|------------------------|--------------------------|--------------------------|
| 4. Do you smoke? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
|------------------------|--------------------------|--------------------------|

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 5. Do you use alcohol, cocaine or other drugs? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

- |                                      |                          |                          |
|--------------------------------------|--------------------------|--------------------------|
| 6. Do you wear contact lenses? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
|--------------------------------------|--------------------------|--------------------------|

Please check all that apply:

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

- |  |     |    |
|--|-----|----|
| 7. Have you had any allergic reactions to the following: | Yes | No |
|--|-----|----|

- |   |                          |                          |
|---|--------------------------|--------------------------|
| Local Anesthetics (eg. novocaine) ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin or other Antibiotics .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa Drugs .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates (sleeping pills) .....     | <input type="checkbox"/> | <input type="checkbox"/> |
| Sedatives .....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Iodine .....                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin .....                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Other .....                             | <input type="checkbox"/> | <input type="checkbox"/> |

- |                          |     |    |
|--------------------------|-----|----|
| 8. (Women Only) Are You: | Yes | No |
|--------------------------|-----|----|

- |                                   |                          |                          |
|-----------------------------------|--------------------------|--------------------------|
| Pregnant? .....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Nursing? .....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Taking birth control pills? ..... | <input type="checkbox"/> | <input type="checkbox"/> |

# Assignment and Release

I hereby authorize payment directly to \_\_\_\_\_ for all insurance benefits otherwise payable to me for services rendered. I understand that 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 \_\_\_\_\_