

# WELCOME

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## ABOUT YOU

Today's Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ File #: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
LAST FIRST MI

What You Prefer To Be Called: \_\_\_\_\_  Male  Female

Birthdate: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

CITY STATE ZIP

Home Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

Work Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_ Ext: \_\_\_\_\_

Cell Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Referred By: \_\_\_\_\_

Employer: \_\_\_\_\_ How Long? \_\_\_\_\_

Employer's Address: \_\_\_\_\_

CITY STATE ZIP

Occupation: \_\_\_\_\_

Status:  Minor  Single  Married  Divorced  Separated  Widowed

Spouse's Name: \_\_\_\_\_

Do you have children?  Yes  No How many? \_\_\_\_\_

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## INSURANCE INFO

Primary Dental Insurance

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

CITY STATE ZIP

Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

Insured's ID#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Secondary Dental Insurance

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

CITY STATE ZIP

Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

Insured's ID#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

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## ACCOUNT INFO

Person ultimately responsible for account

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Billing Address: \_\_\_\_\_

CITY STATE ZIP

SS #: \_\_\_\_\_

Drivers License #: \_\_\_\_\_

Work Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

Payment method:  Cash  Check

Credit Card - Enter card # above (if accepted)

\_\_\_\_\_  
Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

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## IN EVENT OF EMERGENCY

Whom should we contact? \_\_\_\_\_

Relation: \_\_\_\_\_

Home Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

Work Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

Cell Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

Who is your Medical Doctor? \_\_\_\_\_

Medical Doctor's Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

PLEASE CONTINUE ON BACK





# DENTAL INFORMATION

Reason for today's visit:  Exam  Emergency  Consultation  
 Are you in pain?  No  Yes How Long? \_\_\_\_\_  
 Please indicate  any of the following problems:  
 Discomfort, clicking or popping in jaw.  Lost/Broken Filling(s)  Stained teeth  
 Red, swollen or bleeding gums.  Teeth grinding  Locking Jaw  
 Sensitive tooth, teeth or gums.  Ringing in Ears  Bad breath  
 Blisters/Sores in or around the mouth.  Broken/Chipped tooth  
 Other: \_\_\_\_\_  
 Do you require pre-medication?  Yes  No  Don't know  
 Previous Dentist: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Name Phone#  
 Last Dental exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Dental X-rays: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Times a day you brush? \_\_\_\_\_ Times a week you floss? \_\_\_\_\_  
 What type of tooth brush bristles do you use?  Soft  Medium  Hard  
 How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)



# MEDICAL HISTORY

**Are you taking any of the following medications?**  Nerve pills  Pain killers (including aspirin)  
 Muscle relaxers  Stimulants  Blood Thinners  Tranquilizers  Insulin  
 Other(s), please list: \_\_\_\_\_  
**Do you have or have you had any of the following diseases, medical conditions or procedures?**  

<input checked="" type="checkbox"/> Heart Attack / Stroke	<input checked="" type="checkbox"/> Thyroid Problems	<input checked="" type="checkbox"/> Cancer/Tumors	<input checked="" type="checkbox"/> Cosmetic Surgery
<input checked="" type="checkbox"/> Heart Surg./Pacemaker	<input checked="" type="checkbox"/> Kidney Problems	<input checked="" type="checkbox"/> Shingles	<input checked="" type="checkbox"/> Xray or Cobalt Treatment
<input checked="" type="checkbox"/> Heart Murmur	<input checked="" type="checkbox"/> Liver Problems	<input checked="" type="checkbox"/> Hepatitis	<input checked="" type="checkbox"/> Chemotherapy
<input checked="" type="checkbox"/> Rheumatic Fever	<input checked="" type="checkbox"/> Respiratory Problems	<input checked="" type="checkbox"/> HIV+/AIDS/ARC	<input checked="" type="checkbox"/> Asthma
<input checked="" type="checkbox"/> Mitral Valve Prolapse	<input checked="" type="checkbox"/> Sinus Problems	<input checked="" type="checkbox"/> Arthritis/ Rheumatism	<input checked="" type="checkbox"/> Difficulty Breathing
<input checked="" type="checkbox"/> Artificial Valves	<input checked="" type="checkbox"/> Stomach Problems/Ulcers	<input checked="" type="checkbox"/> Artificial Bones/Joints	<input checked="" type="checkbox"/> Diabetes/Hypoglycemia
<input checked="" type="checkbox"/> Heart Disease	<input checked="" type="checkbox"/> Psychiatric Problems	<input checked="" type="checkbox"/> Emphysema	<input checked="" type="checkbox"/> Leukemia
<input checked="" type="checkbox"/> Congenital Heart Defect	<input checked="" type="checkbox"/> Venereal Disease	<input checked="" type="checkbox"/> Fainting/Seizures/Epilepsy	<input checked="" type="checkbox"/> Anemia
<input checked="" type="checkbox"/> Chest Pains	<input checked="" type="checkbox"/> Alcohol/Drug Abuse	<input checked="" type="checkbox"/> Severe/Frequent Headaches	<input checked="" type="checkbox"/> High/Low Blood Pressure
<input checked="" type="checkbox"/> Scarlet Fever	<input checked="" type="checkbox"/> Tuberculosis TB	<input checked="" type="checkbox"/> Frequent Neck Pain	<input checked="" type="checkbox"/> Bleeding Problems
<input checked="" type="checkbox"/> Nervousness	<input checked="" type="checkbox"/> Jaw Problems TMJ/TMD	<input checked="" type="checkbox"/> Back Problems	<input checked="" type="checkbox"/> Glaucoma

 Please list any other surgeries or medical conditions you have or ever had: \_\_\_\_\_  
 Are you allergic to any of the following?  Latex  Penicillin / Amoxicillin  Tetracycline  Aspirin  
 Dental Anesthetics  Others: \_\_\_\_\_  
 Do you use tobacco?  No  Yes/How used? \_\_\_\_\_ How much? \_\_\_\_\_ How long? \_\_\_\_\_  
 Please rate your general health from 1-10: \_\_\_\_\_ Do you wear contact lenses?  Yes  No  
 Have you ever taken the drug Phen-fen and or Redux?  Yes  No  
**For women:** Are you taking Birth Control pills?  Yes  No How many children have you had? \_\_\_\_\_  
 Are you Pregnant?  No  Yes/How long? \_\_\_\_\_ Are you nursing?  Yes  No

PLEASE RECYCLE SO THAT WE CAN PRESERVE THE HEALTH OF OUR PLANET

- ◆ We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- ◆ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- ◆ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- ◆ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Adult Patient  Parent or Guardian  Spouse

**UPDATE (OFFICE USE)**

Initials \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Comments \_\_\_\_\_

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 Comments \_\_\_\_\_

Initials \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Comments \_\_\_\_\_