

# Welcome

We are pleased to welcome you 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

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
*Last Name First Name Initial*

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Email \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Notify in case of emergency \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Email \_\_\_\_\_



## Primary Insurance

Person Responsible for Account \_\_\_\_\_  
*Last Name First Name Initial*

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Email \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Email \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Name of other dependents under this plan \_\_\_\_\_

## Additional Insurance



Is patient covered by additional insurance?  Yes  No

Subscriber Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Subscriber Employed by \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Email \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Email \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Name of other dependents under this plan \_\_\_\_\_

Please complete both sides.





# Dental History

What would you like us to do today? \_\_\_\_\_ Are you in dental discomfort today? \_\_\_\_\_

Former Dentist \_\_\_\_\_ Address \_\_\_\_\_

Dentist's Email \_\_\_\_\_ Phone \_\_\_\_\_

Date of last dental care \_\_\_\_\_ Date of last x-rays \_\_\_\_\_

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

- Y  N Bad breath
- Y  N Food collection between teeth
- Y  N Periodontal treatment
- Y  N Sensitivity to sweets
- Y  N Bleeding gums
- Y  N Grinding or clenching teeth
- Y  N Sensitivity to cold
- Y  N Sensitivity when biting
- Y  N Clicking or popping jaw
- Y  N Loose teeth or broken fillings
- Y  N Sensitivity to hot
- Y  N Sores or growths in mouth

How often do you brush? \_\_\_\_\_ Floss? \_\_\_\_\_

How do you feel about the appearance of your teeth? \_\_\_\_\_

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?  Y  N

Other information about your dental health or previous treatment \_\_\_\_\_

# Medical History



Physician's name \_\_\_\_\_ Phone \_\_\_\_\_

Date of last visit \_\_\_\_\_ Have you had any serious illnesses or operations?  Y  N

If yes, describe \_\_\_\_\_

Are you currently under physician care?  Y  N If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Y  N If yes, give approximate dates \_\_\_\_\_

Have you ever taken Fen-Phen/Redux?  Y  N

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva.  Y  N

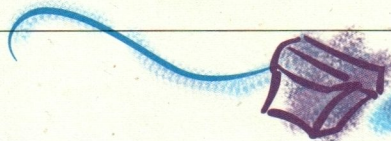
Women: Are you pregnant?  Y  N Nursing?  Y  N Taking birth control pills?  Y  N

Check (✓) yes or no whether you have had any of the following:

- Y  N AIDS/HIV Positive
- Y  N Anaphylaxis
- Y  N Anemia
- Y  N Arthritis, Rheumatism
- Y  N Artificial heart valves
- Y  N Artificial joints
- Y  N Asthma
- Y  N Atopic (allergy prone)
- 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 Headaches
- Y  N Heart murmur
- Y  N Heart problems
- Y  N Describe \_\_\_\_\_
- Y  N Hemophilia/ Abnormal bleeding
- Y  N Herpes
- Y  N Hepatitis
- Y  N High blood pressure
- Y  N Jaw pain
- Y  N Kidney disease or malfunction
- Y  N Liver disease
- Y  N Material allergies (latex, wool, metal, chemicals)
- Y  N Mitral valve prolapse
- Y  N Nervous problems
- Y  N Pacemaker/ Heart surgery
- Y  N Psychiatric care
- 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 Surgical implant
- Y  N Swelling of feet or ankles
- Y  N Thyroid disease or malfunction
- Y  N Tobacco habit
- Y  N Tonsillitis
- Y  N Tuberculosis
- Y  N Ulcer/Colitis
- Y  N Venereal disease

Is patient currently taking any medications? If yes, list all: \_\_\_\_\_

Does patient have drug allergies? If yes, list all: \_\_\_\_\_



# Authorization

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 \_\_\_\_\_

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