

WELCOME

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First Name Initial

If a child, parent's name _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Business Phone _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Patient Employed by _____ Occupation _____

Business Address _____

Email address _____

Whom may we thank for referring you? _____

Person to notify in case of emergency _____

Home phone _____ Cell phone _____

PRIMARY INSURANCE

Person responsible for account _____

Relation to patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Person responsible employed by _____ Occupation _____

Business address _____ Business Phone _____

Insurance Company _____ Phone _____

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 _____

Subscriber employed by _____ Business Phone _____

Insurance company _____ Phone _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

DENTAL HISTORY

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

Former Dentist _____ 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:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Bad Breath | <input type="checkbox"/> Y <input type="checkbox"/> N Food collection between teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Periodontal treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding Gums | <input type="checkbox"/> Y <input type="checkbox"/> N Grinding/clenching teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to cold | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting |
| <input type="checkbox"/> Y <input type="checkbox"/> N Clicking/popping jaw | <input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth or broken fillings | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to hot | <input type="checkbox"/> Y <input type="checkbox"/> 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

Do you have problems getting numb? 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 physicians 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

Do you have a birth defect or genetic condition? Describe _____

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:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive | <input type="checkbox"/> Y <input type="checkbox"/> N Cough, persistent | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis | <input type="checkbox"/> Y <input type="checkbox"/> N Cough up blood | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Disease | <input type="checkbox"/> Y <input type="checkbox"/> N Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis, Rheumatism | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy/Seizures | <input type="checkbox"/> Y <input type="checkbox"/> N Material allergies | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting/dizzy spells | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse | <input type="checkbox"/> Y <input type="checkbox"/> N Skin Rash |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Joints | <input type="checkbox"/> Y <input type="checkbox"/> N Food Allergies (milk) | <input type="checkbox"/> Y <input type="checkbox"/> N Nervous problems | <input type="checkbox"/> Y <input type="checkbox"/> N Stomach Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Osteoporosis/
Osteopenia | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Autoimmune Disease | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker | <input type="checkbox"/> Y <input type="checkbox"/> N Surgical Implant |
| <input type="checkbox"/> Y <input type="checkbox"/> N Back problems | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Care | <input type="checkbox"/> Y <input type="checkbox"/> N Swelling of feet/ankles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood Disorder | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Problems/Surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | Describe _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Rapid weight loss/gain | <input type="checkbox"/> Y <input type="checkbox"/> N Tobacco Habit |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemical Dependency | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/
Abnormal Bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory Disease | <input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cholesterol | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/colitis/IBS | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Circulatory Problems | <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cortisone Treatments | | | |

Is patient currently taking any medications/vitamins/herbs? 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 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 _____