



Welcome to our office

Please fill out the following information as completely as possible. Indicate "N.A." for anything that is not applicable or "same" for duplicate responses. *Thank you*

Patient Information

Name _____
Birthday _____ SSN _____
Home Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ May we text: Y N
E-mail _____ Preferred method of contact Home Cell
Occupation _____ Work Phone _____
How did you hear about our office? _____
Employer name and address _____
City _____ State _____ Zip _____

Spouse Information

Name _____ Cell Phone _____
Birthdate _____ SSN _____
Occupation _____ Work Phone _____
Employer name and address _____
City _____ State _____ Zip _____

Billing Party Information

Who is responsible for this account? _____
Name Relationship to patient

Primary Insurance Information

Insurance Holder _____
Name Relationship to patient
Insurance Company Name _____
Claims Submission Address _____
City _____ State _____ Zip _____
Insurance Company Phone _____
Group # _____
SSN / ID # _____

Secondary Insurance: We do not accept assignment of benefits on secondary insurance. You are asked to pay for anything that your primary insurance does not cover.

I understand and agree that regardless of my insurance status I am ultimately responsible for the balance of my account for any professional services rendered. I authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature for all insurance submissions. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Name of Responsible Party Date

Signature of Responsible Party

Medical History

Patient Name _____ Date of Birth _____

Name of Physician _____

Address _____ City _____ State _____ Zip _____ Phone _____

Have you had any serious illnesses or operations? yes no If 'yes', please describe _____

Please circle 'yes' or 'no':

AIDS/HIV	yes	no	Epilepsy	yes	no	Respiratory disease	yes	no
Anemia	yes	no	Fainting	yes	no	Rheumatic fever	yes	no
Arthritis	yes	no	Glaucoma	yes	no	Scarlet fever	yes	no
Artificial heart valves	yes	no	Headaches	yes	no	Shortness of breath	yes	no
Artificial joints	yes	no	Heart murmur	yes	no	Sinus troubles	yes	no
Asthma	yes	no	Hepatitis	yes	no	Skin rash	yes	no
Back problems	yes	no	Herpes	yes	no	Special diet	yes	no
Bleeding problems	yes	no	High blood pressure	yes	no	Stroke	yes	no
Blood disease	yes	no	Jaundice	yes	no	Swollen feet or ankles	yes	no
Cancer	yes	no	Jaw pain	yes	no	Swollen neck glands	yes	no
Chemical dependency	yes	no	Kidney disease	yes	no	Thyroid problems	yes	no
Chemotherapy	yes	no	Liver disease	yes	no	Tonsilitis	yes	no
Circulatory problems	yes	no	Low blood pressure	yes	no	Tuberculosis	yes	no
Congenital heart lesions	yes	no	Mitral valve prolapse	yes	no	Tumor on head or neck	yes	no
Cortisone treatments	yes	no	Nervous problems	yes	no	Ulcer	yes	no
Cough, persistent or bloody	yes	no	Pacemaker	yes	no	Venereal disease	yes	no
Diabetes	yes	no	Psychiatric care	yes	no	Weight loss, unexplained	yes	no
Emphysema	yes	no	Radiation treatment	yes	no			

Is there any other medical condition you have of which we should be aware? _____

Are there any tactile or sensory issues or sensitivities of which we should be aware? Y N If yes, please explain _____

List any medications you are taking and the correlating diagnosis _____

Do you have any allergies? yes no If 'yes', please list _____

Women: Are you pregnant? _____ Are you nursing? _____

Dental History

Reason for today's visit _____

Name of Dentist _____

Address _____ City _____ State _____ Zip _____ Phone _____

Date of last dental visit _____ Date of last dental x-rays _____

Please circle 'yes' or 'no':

Bleeding gums	yes	no	Loose teeth	yes	no
Blisters on mouth or lips	yes	no	Previous history of orthodontic treatment	yes	no
Burning sensation on tongue	yes	no	Previous history of periodontal treatment	yes	no
Cigarette, pipe, or cigar smoking	yes	no	Sensitivity to cold	yes	no
If 'yes': How much/day _____			Sensitivity to heat	yes	no
How many years _____			Sensitivity to sweets	yes	no
Do you grind your teeth	yes	no	Sensitivity to biting	yes	no
Dry mouth	yes	no	Sores or growths in mouth	yes	no
Food collection between teeth	yes	no	How often do you brush? _____		
Swollen or painful gums	yes	no	How often do you floss? _____		
Jaw pain, clicking or popping	yes	no	History of Speech Therapy	yes	no

I certify that the above information is correct to the best of my knowledge.

Signed _____ Date _____