

# WELCOME TO OUR PRACTICE!



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 DENTAL INSURANCE

Person Responsible for Account \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Last Name First Name Initial

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 \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Last Name First Name Initial

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

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

Insured Employed By \_\_\_\_\_ Business Phone \_\_\_\_\_

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

Insurance Company Address \_\_\_\_\_

Subscriber I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

Please complete reverse side

## DENTAL HISTORY

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

City, State \_\_\_\_\_

Date of Last Dental Visit \_\_\_\_\_

Date of Last X-Rays \_\_\_\_\_

How Often Do You Floss? \_\_\_\_\_

How Often Do You Brush? \_\_\_\_\_

Please check all that apply:

Bad Breath.....   
 Bleeding Gums .....   
 Blisters on Lips or Mouth .....   
 Finger Nail Biting .....   
 Grinding Teeth .....   
 Lip or Cheek Biting .....

Loose Teeth or Broken Fillings.....   
 Orthodontic Treatment .....   
 Pain Around Ear .....   
 Periodontal Treatment .....   
 Sensitivity to Cold .....   
 Sensitivity to Heat .....

Sensitivity to Sweets .....   
 Sensitivity When Biting .....   
 Frequent Headaches .....   
 Jaw, Head or Neck Injuries .....   
 Jaw Difficulty: Clicking and/or Pain..   
 Tooth Pain .....

## MEDICAL HISTORY

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

1. Are you currently under medical treatment? .....  Yes  No

2. Have you ever had any serious illnesses or operations? .....  Yes  No

3. Are you currently taking any medication? .....  Yes  No

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

4. Do you smoke? .....  Yes  No

5. Do you use alcohol, cocaine or other drugs? .....  Yes  No

6. Do you wear contact lenses? .....  Yes  No

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:

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

Please check all that apply:

AIDS .....   
 Anemia.....   
 Arthritis, Rheumatism .....   
 Artificial Heart Valves .....   
 Artificial Joints .....   
 Asthma .....   
 Back Problems .....   
 Bleeding abnormally,  
 with extractions or surgery .....   
 Blood Disease .....   
 Cancer .....   
 Chemical Dependency .....   
 Chemotherapy .....   
 Chronic Fatigue Syndrome .....   
 Circulatory Problems .....   
 Congenital Heart Lesions.....   
 Cortisone Treatments .....   
 Cough - persistent or bloody.....   
 Diabetes.....

Emphysema .....   
 Epilepsy .....   
 Fainting or Dizziness .....   
 Glaucoma .....   
 Headaches.....   
 Heart Murmur .....   
 Heart Problems.....   
 Hepatitis-Type \_\_\_\_\_ .....   
 Herpes.....   
 High Blood Pressure .....   
 HIV Positive .....   
 Jaundice .....   
 Jaw Pain .....   
 Latex Sensitivity .....   
 Kidney Disease .....   
 Liver Disease.....   
 Low Blood Pressure .....   
 Mitral Valve Prolapse.....   
 Nervous Problems.....

Pacemaker.....   
 Psychiatric Care .....   
 Radiation Treatment.....   
 Respiratory Disease.....   
 Rheumatic Fever .....   
 Scarlet Fever .....   
 Shortness of Breath .....   
 Sinus Trouble.....   
 Skin Rash .....   
 Stroke .....   
 Swelling of Feet/Ankles.....   
 Swollen Neck Glands.....   
 Thyroid Problems.....   
 Tonsillitis .....   
 Tuberculosis.....   
 Tumor or growth on head/neck.....   
 Ulcer.....   
 Venereal Disease .....

## 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 \_\_\_\_\_