Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet your entire dental healthcare needs, please fill out the following forms.
If you have any questions or need assistance please ask us. We will be happy to help.

Patient Information:

Patient Name: ______________________________ Date: __________
Last, First MI (Nickname)
Social Security #: ______________ Birth Date: __________ Gender: M/F
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Address: ____________________ City: __________ State: ____ Zip: ______
Phone: (Home)______________ (Work)______________ (Cell)______________
E-mail Address: ______________________
Emergency Contact: ________________________ Phone: ____________

Employment Information

Employer Name: ________________________ Occupation: ____________
Address: ____________________ City: __________ State: ____ Zip:______
Phone: ______________

Responsible Party Information

Name: ______________________________ SSN#: __________ Birth Date: ______
Last, First MI (Nickname)
Address: ____________________ City: __________ State: ____ Zip:______
Phone: (Home)______________ (Work)______________ (Cell)______________
E-mail Address: ______________________

Primary Insurance Company

Insurance Company Name: ______________________________
Subscriber Name: ____________________________ Date of Birth: __________
Policy/ID Number: ____________________ Group Number: ____________
Address: ____________________ City: __________ State: _____ Zip: ______

Secondary Insurance Company

Insurance Company Name: ______________________________
Subscriber Name: ____________________________ Date of Birth: __________
Policy/ID Number: ____________________ Group Number: ____________
Address: ____________________ City: __________ State: _____ Zip: ______

Referral Information
Whom may we thank for referring you to our practice? ____________________________

Health Information

Have you ever had any of the following? Please check those that apply:

- ❑ AIDS/HIV
- ❑ Alcohol Use
- ❑ Allergies ____________ ____________
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Blood Disease
- ❑ Cancer
- ❑ Contact Lens Use
- ❑ Diabetes
- ❑ Dizziness
- ❑ Epilepsy
- ❑ Excessive Bleeding
- ❑ Fainting
- ❑ Glaucoma
- ❑ Growths
- ❑ Hay Fever
- ❑ Head Injuries
- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ Jaundice
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mental Disorders
- ❑ Nervous Disorders
- ❑ Pacemaker
- ❑ Radiation Therapy
- ❑ Respiratory Problems
- ❑ Rheumatic Fever
- ❑ Rheumatism
- ❑ Sinus Problems
- ❑ Stomach Problems
- ❑ Stroke
- ❑ Tobacco Use
- ❑ Tuberculosis
- ❑ Tumors
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ OTHER ____________ ____________

Please check those that apply:

Are you allergic to or have you had any reactions to the following?

- ❑ Local Anesthetics
- ❑ Penicillin or any other Antibiotics
- ❑ Sulfa Drugs
- ❑ Barbiturates
- ❑ Sedatives
- ❑ Iodine
- ❑ Aspirin
- ❑ Any Metals (e.g. nickel, mercury etc)
- ❑ Latex Rubber
- ❑ Other (please list) ____________________

Please list all any medications (including non-prescription medicine) that you are currently taking

____
____
____
____

Women Only:

- ❑ Pregnant or think you may be pregnant
- ❑ Nursing?
- ❑ Taking Oral Contraceptives

Have you ever had any complications following dental treatment? Yes/No
If yes, please explain: ________________________________

Have you been admitted to a hospital or needed emergency care during the past two years? Yes/No
If yes, please explain: ________________________________

Are you now under the care of a physician? Yes/No
If yes, please explain: ________________________________

Do you have any health problems that need further clarification? Yes/No

Name of Physician: ________________________ Phone: ______________
Name of Previous Dentist: ____________________ Phone: ______________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

________________________________ Date: ______________
Signature of patient, parent or guardian