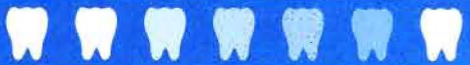 WELCOME

Thank you for selecting our dental health care team! We will strive to provide you with the best possible dental care.
To help us meet all your dental health care needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us—we will be happy to help.

Patient Information (CONFIDENTIAL)

Today's Date__________

Name__________ Birthdate__________ SS#__________

Address__________ City__________ State____ Zip______

E-mail address__________ Home phone__________ Cell phone__________

Patient or parent/guardian's employer__________ Occupation__________

Business address__________ Business Phone__________

Check appropriate box ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Person to contact in case of emergency__________

Whom may we thank for referring you?__________

Responsible Party for Account

Name__________ Relationship to patient__________

Address__________ City__________ State____ Zip______

Employer__________ Work Phone__________ Home Phone__________

Birthdate__________

Additional responsible party for account__________

Relationship to patient__________ Work Phone__________ Home Phone__________

Dental Insurance Information

Name of Insured__________ Relationship to patient__________

Birthdate__________ Social Security Number__________

Name of Employer__________

Address of Employer__________

Insurance Company__________ Group Number__________

Insurance Co. Address__________ Ins. Co. Phone Number__________

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ❑ Yes ❑ No

If yes, please complete the following:

Name of Insured__________ Relationship to patient__________

Birthdate__________ Social Security Number__________

Name of Employer__________

Address of Employer__________

Insurance Company__________ Group Number__________

Insurance Co. Address__________ Ins. Co. Phone Number__________

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Patient Medical History

Physician____________________ Office phone__________ Date of last exam__________

Are you under medical treatment now? ❑ Yes ❑ No

If yes, please explain ____________________

Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? ❑ Yes ❑ No

If yes, please explain ____________________

Are you taking any medication(s)? ❑ Yes ❑ No

If yes, please list ____________________

Do you have any allergies? ❑ Yes ❑ No

Penicillin or any other antibiotics ❑ Yes ❑ No Please explain____________________

Latex rubber ❑ Yes ❑ No

Other____________________

Do you have or have you had any of the following?

High blood pressure	❑ Yes	❑ No	AIDS or HIV infection	❑ Yes	❑ No
Heart attack or heart discease	❑ Yes	❑ No	Joint replacement	❑ Yes	❑ No
Heart pacemaker	❑ Yes	❑ No	Hepatitis/jaundice	❑ Yes	❑ No
Rheumatic fever	❑ Yes	❑ No	Mitral valve prolapse	❑ Yes	❑ No
Scarlet fever	❑ Yes	❑ No	Other	❑ Yes	❑ No
Heart murmur	❑ Yes	❑ No	If yes, please explain__________		
Diabetes	❑ Yes	❑ No			

Women only:

Are you pregnant or think you may be pregnant? ❑ Yes ❑ No

Patient Dental History

Name of previous dentist and location____________________

Date of last exam____________________ Date of last cleaning____________________

Date of last X-rays____________________

Have you ever taken an antibiotic as a premed before dental treatment?	❑ Yes	❑ No
Do you feel pain in any of your teeth?	❑ Yes	❑ No
Do your gums bleed while brushing or flossing?	❑ Yes	❑ No
Are your teeth sensitive to hot or cold temperatures?	❑ Yes	❑ No
Do you have any sores or lumps in your mouth?	❑ Yes	❑ No
Do you have any jaw problems (TMJ)?	❑ Yes	❑ No
Do you have frequent headaches?	❑ Yes	❑ No
Do you clench or grind your teeth?	❑ Yes	❑ No
Have you had any orthodontic treatment?	❑ Yes	❑ No
Do you wear partials or dentures?	❑ Yes	❑ No
Do you like your smile?	❑ Yes	❑ No

If you could change one thing about your smile, what would it be?____________________

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X____

Signature of patient (or parent/guardian if minor)