

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 needs, please fill out this form completely. 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 (IF DIFFERENT FROM PATIENT INFORMATION)

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 _____ INSURANCE CO. PHONE NUMBER _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? Yes No

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____

NAME OF EMPLOYER _____

ADDRESS OF EMPLOYER _____

INSURANCE COMPANY _____ GROUP NUMBER _____

INSURANCE CO. ADDRESS _____ INSURANCE CO. PHONE NUMBER _____

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 thee last 5 years? Yes No

If yes, please explain _____

Are you taking any medications(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

Heart attack or heart disease Yes No

Heart pacemaker Yes No

Rheumatic fever Yes No

Scarlet fever Yes No

Heart murmur Yes No

Diabetes Yes No

AIDs or HIV infection Yes No

Joint replacement Yes No

Hepatitis/jaundice Yes No

Mitral valve prolapse Yes No

Other Yes No

If yes, please explain _____

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 headache? 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 record 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 thee 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 the payment of all services rendered on my behalf or my dependents.

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN IF MINOR) _____