



Welcome

Thank you for selecting us.

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Patient Number _____

Name _____ Date _____

Soc. Sec. # _____ Birthdate _____ Home Phone _____
State/Prov. _____ Zip/Post. Code _____

Address _____ City _____

Check Appropriate Box: Minor Single Married Separated Divorced Widowed
State/Prov. _____ Full Time Part Time

If Student, Name of School/College _____ City _____

Patient's or Parent's Employer _____ Work Phone _____
State/Prov. _____ Zip/Post. Code _____

Business Address _____ City _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____ *cell*

Person to Contact in Case of Emergency _____ Phone _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

1. Are you under medical treatment now?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	9. Are you allergic to or have you had any reactions to the following:	Yes	No
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetics (e.g. Novocain)	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever taken Phen-Fen/Redux?	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you use controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives	<input type="checkbox"/>	<input type="checkbox"/>
7. Are you wearing contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	Iodine	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have or have you had any of the following?	Yes	No	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Any Metals (e.g. nickel, mercury, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Latex Rubber	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	10. Women Only:		
Fainting/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	a) Are you pregnant or think you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	b) Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	c) Are you taking oral contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Allergies	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
			Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
			Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
			Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
			Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
			Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
			Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
			Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Over Please

Patient Dental History

Name of Previous Dentist and Location (optional) _____ Date of Last Exam _____

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had any difficult extractions in the past?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had any prolonged bleeding following extractions?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel pain to any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you had any orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you wear dentures or partials? If yes, date of placement _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever experienced any of the following problems in your jaw? Clicking <input type="checkbox"/> <input type="checkbox"/> Pain (joint, ear, side of face) <input type="checkbox"/> <input type="checkbox"/> Difficulty in opening or closing <input type="checkbox"/> <input type="checkbox"/> Difficulty in chewing <input type="checkbox"/> <input type="checkbox"/>			16. Do you like your smile?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	17. Have you ever had a bad experience with another Dentist or Physician?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	18. Why did you leave your last Dentist? _____ _____		
			19. Please add anything else you feel is important. _____ _____		

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
 Address _____ Home Phone _____
 Driver's License # _____ Birthdate _____ Financial Institution _____
 Employer _____ Work Phone _____ SSN# _____
 Is this Person Currently a Patient in our Office? Yes No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash Personal Check Credit Card VISA MasterCard

Insurance information

Name of Insured _____ Relationship to Patient _____
 Birthdate _____ Social Security # _____ Date Employed _____
 Name of Employer _____ Union or Local # _____ Work Phone _____
 Employer Address _____ City _____ State/Prov. _____ Zip/Post. Code _____
 Insurance Company _____ Group # _____ Policy/ID # _____
 Ins. Co. Address _____ City _____ State/Prov. _____ Zip/Post. Code _____
 How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Do You Have Any Additional Insurance? Yes No If Yes, Complete the Following

Name of Insured _____ Relationship to Patient _____
 Birthdate _____ Social Security # _____ Date Employed _____
 Name of Employer _____ Union or Local # _____ Work Phone _____
 Employer Address _____ City _____ State/Prov. _____ Zip/Post. Code _____
 Insurance Company _____ Group # _____ Policy/ID # _____
 Ins. Co. Address _____ City _____ State/Prov. _____ Zip/Post. Code _____
 How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

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 or dental group 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 if minor)

Insurance: To avoid misunderstanding regarding dental insurance, we wish the persons Responsible to know that all professional services rendered are charged directly to them and that they are personally responsible for payment of fees. We will prepare necessary forms or reports to help the persons responsible obtain benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay for our fees.

Appointments: A minimum charge will be made for failed or canceled appointment without Prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, Please remember this time is reserved for the patient.

Signature _____ Date _____