WELCOME

Patient Information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please print)

Name_____ Prefers to be called_____
First MI Last

Address_____City_____State_____Zip_____

Birthdate_____Home Phone #_____Work Phone #_____

Cell/Pager #_____E-mail_____

I prefer to be contacted ☐ Home ☐ Work ☐ Cell ☐ Email

Person to contact in case of emergency_____Phone #_____

Are you: ☐ Minor ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated

Your or your parent's employer_____Occupation_____

Business Address_____City_____State_____Zip_____

Spouse's or parent's name_____Workplace_____Work Phone #_____

If you are a student, name of school/college_____City_____State_____

Whom may we thank for referring you to us?_____

Insurance Information

Name of insured_____ Relationship to patient_____

Birthdate_____Social Security #_____Date employed_____

Name of Employer_____Work Phone#_____

Insurance Co._____Group #_____Employer #_____

Your insurance is a method to receive reimbursement for services you have received. Having insurance is not a substitute for payment. Many companies have fixed payments or pay percentages of a fixed schedule based on your contract with them. Our office will assist you in getting maximum reimbursements from your insurance company, but you are responsible for the total amount due for the services rendered to you. This includes annual deductibles, co-insurance and those amounts not covered or considered above usual and customary by your insurance carrier.

_____*(initial)*

Dental History

Former Dentist _____ Phone # _____

Reason for leaving former dentist _____

Reason for today's visit _____

Date of last exam _____ Date of last dental X-rays _____

How often do you brush? _____ How often do you floss? _____

Please check any of the following conditions that apply to you:

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Grinding teeth
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Previous orthodontic treatment
- ☐ Sensitivity to cold
- ☐ Jaw pain
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth
- ☐ Sensitivity to hot

How do you feel about the appearance of your teeth? _____

Have you ever considered whitening your teeth? _____

Medical History

Physician _____ Phone # _____ Date of last visit _____

Please list all medications you are currently taking: _____

_____

Allergies: _____

Have you had any surgery in the last five years? _____ Explain _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking Birth control pills? ☐ Yes ☐ No

Do you have a history of the following? *(Check all that apply.)*

- ☐ AIDS/HIV Pos
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up blood
- ☐ Dementia
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems

  Describe _____

  _____
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Psychiatric care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of feet or ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

☐ Any other diseases not listed here _____

_____

I have answered these questions to the best of my knowledge. Thank you for your cooperation. Please be sure that this information is confidential. By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

X _____ *Date* _____

Signature of patient (or parent if minor)