Welcome!

Patient Information

Date _____ Soc..Sec. #_____Date of Birth_____

Full Name_____ Home Phone_____

Address_____Cell Phone_____

City_____State_____Zip_____E-mail_____

Sex: M F

Minor Single Married Long Term Partner Divorced Widowed Separated

Employer_____Business Phone_____

Business Adress_____Occupation_____

Who should we thank for referring you ?_____

In case of emergency, whom should we contact? _____Phone_____

Primary Insurance

Person Responsible for Account _____

Relationship to patient_____ Date of Birth :_____Soc.Sec.#_____

Address_____ Primary Phone No_____

City_____State_____Zip_____

Responsible party Employed By _____Business Phone_____

Business Address_____Occupation_____

Insurance Company_____

Insurance Company Address_____

Subscriber I.D.#_____Group#_____

Additional Insurance

Person Responsible for Account _____

Relationship to patient_____ Date of Birth :_____Soc.Sec.#_____

Address_____ Primary Phone No_____

City_____State_____Zip_____

Responsible party Employed By _____Business Phone_____

Business Address_____Occupation_____

Insurance Company_____

Insurance Company Address_____

Subscriber I.D.#_____Group#_____

Dental History

Former Dentist _____
City, State _____
Date of last Dental Visit _____

Date of Last X-Rays _____
How Often Do You Floss? _____
How Often Do You Brush? _____

Please check all that apply:

Bad Breath .....
Bleeding Gums.....
Blisters on Lips or Mouth .....
Finger Nail Biting .....
Grinding Teeth .....
Lip or Cheek Biting .....

Loose Teeth or Broken Filings.....
Orthodontic Treatment.....
.....
.....
.....
.....

Sensitivity to Sweets .....
Sensitivity When Biting.....
Frequent Headaches.....
Jaw, Head or Neck Injuries.....
Jaw Difficulty: Clicking and/or Pain...
Tooth Pain.....

Medical History

Physician's Name_____ Date of Last Visit _____

1. Are you currently under medical treatment? .....
2. Have you ever had any serious illnesses or operations? .....
3. Are you currently taking any medication? .....
   Please describe: _____
   _____
4. Do you smoke? .....
5. Do you use alcohol, Cocaine or other drug's? .....
6. Do you wear contact lenses? .....

7. Have you had any allergy reactions to the following:
   - Local Anesthetics (eg.novocaine).....
   - Penicillin or other antibiotics.....
   - Sulfa Drugs .....
   - Barbiturates(sleeping pills) .....
   - Iodine.....
   - Aspirin.....
   - Others.....
8. (Women only) Are you:
   - Pregnant?.....
   - Nursing?.....
   - Taking birth control pills .....

Please check all that apply:

AIDS .....
Anemia .....
Arthritis, Rheumatism .....
Artificial Heart valves .....
Artificial joints.....
Asthma .....
Back problems .....
Bleeding abnormally
With extraction or surgery ...
Blood Disease .....
Cancer.....
Chemical Dependency .....
Chemotherapy .....
Chronic Fatigue Syndrome....
Circulatory Problem.....
Congenital Heart Lesions.....
Cortisone Treatment .....
Cough-Persistent or bloody,
Diabetes .....

Emphysema .....
Epilepsy.....
Fainting or Dizziness....
Glaucoma .....
Headaches .....
Heart Murmur.....
Heart Problems.....
Hepatitis-Type:.....
Herpes.....
High Blood Pressure .....
HIV Positive .....
Jaundice .....
Jaw Pain .....
Kidney Disease.....
Latex Sensitivity .....
Liver Disease .....
Low Blood Pressure.....
Mitral Valve Prolapse .....
Nervous Problems .....

Pacemaker.....
Psychiatric Care .....
Radiation Treatment .....
Respiratory Disease.....
Rheumatic Fever .....
Scarlet Fever.....
Shortness of Breath.....
Sinus Trouble.....
Skin Rash.....
Stroke .....
Swelling of Feet/Ankles.....
Swollen Neck Glands.....
Thyroid Problem .....
Tonsillitis.....
Tuberculosis .....
Tumor or growth on head/neck .....
Ulcer.....
Venereal Disease .....

Assignment and Release

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date: _____