

Patient I.D. # \_\_\_\_\_

# WELCOME



*Thank you for your visit today! We appreciate you trusting us to care for your dental health, and are pleased to welcome you to our practice. To help us serve you better, please take a few moments to fill out the following form as completely as you can. If you have any questions, just ask – we will be glad to help. We look forward to working with you!*



## PATIENT INFORMATION

Date \_\_\_\_\_ Home phone \_\_\_\_\_

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Sex  Male  Female Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  Married  Widowed  Divorced  Separated

Occupation \_\_\_\_\_ Employed by \_\_\_\_\_

Business address \_\_\_\_\_ Work phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Whom may we notify in case of an emergency? \_\_\_\_\_ Phone \_\_\_\_\_

## PRIMARY INSURANCE

Who is responsible for this account? \_\_\_\_\_

Name \_\_\_\_\_

Relation to patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

Address (if different from patient's) \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business address \_\_\_\_\_ Work phone \_\_\_\_\_

Insurance company \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Names of other dependents covered by this plan \_\_\_\_\_

## SECONDARY INSURANCE

Is patient covered by additional insurance?  Yes  No

Subscriber name \_\_\_\_\_ Relation to patient \_\_\_\_\_

Address (if different from patient's) \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Subscriber employed by \_\_\_\_\_ Work phone \_\_\_\_\_

Insurance company \_\_\_\_\_ Social Security # \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Names of other dependents covered by this plan \_\_\_\_\_

*Please Complete Both Sides*

## DENTAL HEALTH HISTORY

Reason for today's visit \_\_\_\_\_

Previous dentist \_\_\_\_\_

Address \_\_\_\_\_

Date of last dental care \_\_\_\_\_ Last dental x-rays \_\_\_\_\_

Please check (✓) if you have had trouble with any of the following:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad Breath                    | <input type="checkbox"/> Grinding Teeth                 | <input type="checkbox"/> Sensitivity to Heat            |
| <input type="checkbox"/> Bleeding Gums                 | <input type="checkbox"/> Loose Teeth or Broken Fillings | <input type="checkbox"/> Sensitivity to Sweets          |
| <input type="checkbox"/> Clicking or Popping Jaw       | <input type="checkbox"/> Periodontal Treatment          | <input type="checkbox"/> Sensitivity when Biting        |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to Cold            | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

## MEDICAL HISTORY

Physician's name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Previous hospitalizations, illnesses, or operations (please describe, and give approximate date) \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No If yes, please give approximate date \_\_\_\_\_

Women: Are you pregnant?  Yes  No Nursing?  Yes  No Taking birth control pills?  Yes  No

Please check (✓) if you have or have had any of the following:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> AIDS                    | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cough, Persistent    | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Cough up Blood       | <input type="checkbox"/> HIV Positive          | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Swelling of Feet or ankles |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Nervous Problems      | <input type="checkbox"/> Tobacco Habit              |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Chemotherapy            | Describe _____                                | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Ulcer                      |
| <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Venereal Disease           |

Please list any medications you are currently taking \_\_\_\_\_

Please list any allergies \_\_\_\_\_

## AUTHORIZATION

I have reviewed this questionnaire and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment, and I agree to notify the dentist if any change in my health status should occur.

I authorize the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize use of this signature on all insurance submissions.

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.

Signature \_\_\_\_\_ Date \_\_\_\_\_

***Payment is due in full at time of treatment, unless prior arrangements have been approved.***