Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as possible. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name_____Soc. Sec. #_____
Last Name First Name Initial

Home Address_____
Street City State Zip

Sex [ ]M [ ]F Birthdate_____ [ ]Single [ ]Married [ ]Divorced Home Phone_____

Cell Phone _____ Email address _____

Whom may we thank for referring you? _____

Emergency contact_____ Telephone_____

INSURANCE

Name of Insured_____ Relation to patient_____

Soc. Sec. # _____ Birthdate _____

of insured

Employer _____ Business Phone _____

Business Address _____
Street City State Zip

Insurance company_____ Address_____
Street City State Zip

Group # _____ Policy #_____ Telephone #_____

Is Patient Covered by Additional Insurance? [ ] Yes [ ] No

If Yes: Subscriber Name_____Relation to patient_____Birthdate_____

Employer_____ Soc. Sec. #_____

Business Address_____ Business Phone #_____
Street City State Zip

Insurance company_____ Address_____

Group # _____ Policy #_____ Telephone #_____

DENTAL HISTORY

What would you like us to do today? _____ Are you in dental discomfort today?_____

Former
Dentist:_____Address:_____Phone:_____
Street City State Zip

Date of last dental care: _____ Date of last x-rays:_____

Check if you have had problems with any of the following:

[ ] Bad breath	[ ] Food collection between teeth	[ ] Periodontal treatment	[ ] Sensitivity to sweets
[ ] Bleeding gums	[ ] Grinding or clenching teeth	[ ] Sensitivity to cold	[ ] Sensitivity when biting
[ ] Clicking or popping jaw	[ ] Loose teeth or broken fillings	[ ] Sensitivity to hot	[ ] Sores or growths in mouth

How often do you brush? _____Floss? _____

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

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? [ ]Yes [ ]No

Other information about your dental health or previous treatment: _____

MEDICAL HISTORY

Physician's name _____Telephone_____

Date of last visit? _____Have you had any serious illnesses or operations? [ ]Yes [ ]No

If yes, please describe_____

Are you currently taking any medications? [ ]Yes [ ]No If yes, please list _____

Are you allergic to any medications? [ ] Yes [ ] No If yes, please list_____

WOMEN: Are you pregnant? [ ]Yes [ ]No Nursing? [ ]Yes [ ]No Taking birth control pills? [ ]Yes [ ]No

Check if you have had problems with any of the following:

[ ] Anemia	[ ] Glaucoma	[ ] HIV	[ ] Pneumonia
[ ] Arthritis	[ ] Headaches	[ ] Kidney disease	[ ] Rheumatic fever
[ ] Asthma	[ ] Hearing Problems	[ ] Latex allergy	[ ] Sinus problems
[ ] Cancer	[ ] Heart murmur	[ ] Liver disease	[ ] Stroke
[ ] Diabetes	[ ] Heart problems	[ ] Low/High blood pressure	[ ] Thyroid disease
[ ] Epilepsy	[ ] Hepatitis	[ ] Lung problems	[ ] Tobacco use
[ ] Fainting	[ ] Herpes	[ ] Mental health	[ ] Tuberculosis

[ ] Other (please specify)_____

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges including collection fees and interest, whether or not paid by insurance.

Signature x_____Date _____