WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. We look forward to working with you in maintaining your dental health. Whom may we thank for referring you to our office?_____

PATIENT INFORMATION

Date_____ Name_____ SS #_____
First Middle Initial Last

Address_____City_____State_____ Zip_____

Home Phone (_____) _____ Cell Phone (_____)_____ Work Phone (_____)_____

Sex: _____Female _____Male Birthdate: _____ Drivers Lic. #_____ State_____

_____Single _____Married _____Widowed _____Separated _____ Divorced _____ Partnered for _____ Years

Is Patient a Full/Part time Student? If so, name of school _____

Patient Employed By_____ Occupation _____

Business Address_____ City_____ Business Phone _____

Name of Nearest Relative Not Living With You_____ Relationship _____

Complete Address_____ Home #_____ Cell # _____

Emergency Contact_____ Home #_____ Cell #_____

RESPONSIBLE PARTY

Name of Person Responsible for This Account _____

Relationship to Patient_____ Birthdate_____ SS#_____

Address_____City_____State_____Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

INSURANCE INFORMATION

Name of Insured _____

Relationship to Patient _____Birthdate_____SS#_____

Name of Employer_____ Work Phone _____

Address_____City_____State_____Zip_____

Insurance Co._____ Group #_____ Phone _____

Insurance Co. Address_____City_____State_____ Zip_____

ADDITIONAL INSURANCE

Is Patient covered by additional Insurance? _____ Yes _____ No

Name of Insured _____

Relationship to Patient_____Birthdate_____SS# _____

Name of Employer_____ Work Phone _____

Address _____ City _____ State _____ Zip_____

Insurance Co. _____ Group # _____ Phone _____

Insurance Co. Address_____City_____State _____Zip_____

Please complete both sides

DENTAL HISTORY

Are you in dental discomfort today? _____

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

Former Dentist _____ Address _____

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

Yes/No	Bad breath	Yes/No	Grinding or clenching teeth	Yes/No	Sensitivity to hot/cold
Yes/No	Bleeding gums	Yes/No	Loose/Broken teeth	Yes/No	Sensitivity to sweets
Yes/No	Clicking or popping jaw	Yes/No	Loose/Broken fillings	Yes/No	Sensitivity when biting
Yes/No	Food collecting between teeth	Yes/No	Periodontal treatment	Yes/No	Sores or growths in mouth

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

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

Have you ever had any adverse reaction to a dental or medical procedure? Yes/No

If yes, please explain _____

MEDICAL HISTORY

Physician's name _____City _____Phone _____Date of last visit_____

Have you had any serious illness or operations? Yes/No If yes, describe_____

Are you currently under physician care? Yes/No If yes, describe _____

Have you ever taken Fen-Phen/Redux? Yes/No Are you taking Bis-Phosphonates? Yes/No

Have you ever had a blood transfusion? Yes/No Date :_____

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

Please indicate if you have had or have at present any of the following:

Yes/No	AIDS/HIV Positive	Yes/No	Food allergies	Yes/No	Rapid weight gain or loss
Yes/No	Anemia	Yes/No	Glaucoma	Yes/No	Radiation treatment
Yes/No	Arthritis/ Rheumatism	Yes/No	Headaches	Yes/No	Respiratory disease
		Yes/No	Heart murmur	Yes/No	Rheumatic/Scarlet fever
Yes/No	Artificial heart valves	Yes/No	Heart problems	Yes/No	Shingles
Yes/No	Artificial joints	Yes/No	Hemophilia/ Abnormal bleeding	Yes/No	Shortness of breath
Yes/No	Asthma			Yes/No	Skin rash
Yes/No	Back problems	Yes/No	Herpes	Yes/No	Spina Bifida
Yes/No	Blood disease	Yes/No	Hepatitis	Yes/No	Stroke
Yes/No	Cancer	Yes/No	High blood pressure	Yes/No	Surgical Implant
Yes/No	Chemotherapy	Yes/No	Jaw pain	Yes/No	Swelling of feet or ankles
Yes/No	Circulatory problems	Yes/No	Kidney disease/malfunction	Yes/No	Thyroid disease
Yes/No	Cortisone treatments	Yes/No	Liver disease	Yes/No	Tobacco habit
Yes/No	Cough, persistent	Yes/No	Material allergies (latex, metal, chemicals)	Yes/No	Tonsillitis
Yes/No	Cough up blood			Yes/No	Tuberculosis
Yes/No	Diabetes	Yes/No	Mitral valve prolapse	Yes/No	Ulcer/Colitis
Yes/No	Drug/Alcohol addiction	Yes/No	Nervous problems	Yes/No	Venereal disease
Yes/No	Epilepsy	Yes/No	Pacemaker/Heart surgery	Yes/No	Other: _____
Yes/No	Fainting/Dizzy spells	Yes/No	Psychiatric care		_____

Are you currently taking any medications? If yes, list all:_____

Do you have any drug allergies? If yes, list all: _____

AUTHORIZATION & CONSENT

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

I authorize the insurance company indicated to pay the dentist all benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk.

I understand that all responsibility for payment for dental service provided to me is mine. Payment is due at time of service, unless prior arrangements have been made. I understand that a 1 ½% finance charge (18%APR) may be added to my account, as well as any collection charges. I understand this office has a cancellation policy and that a fee may be added if less than 24 hour notice is given.

I understand that it is my responsibility to advise this office of any changes to the information contained on this form.

_____	_____	_____	_____
Signature of Patient, Parent, Guardian	Print Name	Relationship	Date

FOR OFFICE USE: Reviewed by Dr._____ Date _____