

# WELCOME

## 1 one

### ABOUT YOU

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ File #: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
LAST FIRST MI

What You Prefer To Be Called: \_\_\_\_\_  Male  Female

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ SS#: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

CITY STATE ZIP

Home Phone #: (\_\_\_\_) \_\_\_\_\_

Work Phone #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

Cell Phone #: (\_\_\_\_) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Referred By: \_\_\_\_\_

Employer: \_\_\_\_\_ How Long? \_\_\_\_\_

Employer's Address: \_\_\_\_\_

CITY STATE ZIP

Occupation: \_\_\_\_\_

Status:  Minor  Single  Married  Divorced  Separated  Widowed

Spouse's Name: \_\_\_\_\_

Do you have children?  Yes  No How many? \_\_\_\_\_

## 3 three

### ACCOUNT INFO

Person ultimately responsible for account

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Billing Address: \_\_\_\_\_

CITY STATE ZIP

SS #: \_\_\_\_\_

Drivers License #: \_\_\_\_\_

Work Phone #: (\_\_\_\_) \_\_\_\_\_

Payment method:  Cash  Check

Credit Card - Enter card # above (if accepted)

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Initials

## 2 two

### INSURANCE INFO

Primary Dental Insurance

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

CITY STATE ZIP

Phone #: (\_\_\_\_) \_\_\_\_\_

Insured's ID#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insured's Employer: \_\_\_\_\_

Secondary Dental Insurance

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

CITY STATE ZIP

Phone #: (\_\_\_\_) \_\_\_\_\_

Insured's ID#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insured's Employer: \_\_\_\_\_

## 4 four

### IN EVENT OF EMERGENCY

Whom should we contact? \_\_\_\_\_

Relation: \_\_\_\_\_

Home Phone #: (\_\_\_\_) \_\_\_\_\_

Work Phone #: (\_\_\_\_) \_\_\_\_\_

Cell Phone #: (\_\_\_\_) \_\_\_\_\_

Who is your Medical Doctor? \_\_\_\_\_

Medical Doctor's Phone #: (\_\_\_\_) \_\_\_\_\_

PLEASE CONTINUE ON BACK



5  
five

6  
six

## DENTAL INFORMATION

Reason for today's visit:  Exam  Emergency  Consultation  
 Are you in pain?  No  Yes How Long? \_\_\_\_\_  
 Please indicate  any of the following problems:  
 Discomfort, clicking or popping in jaw.  Lost/Broken Filling(s)  Stained teeth  
 Red, swollen or bleeding gums.  Teeth grinding  Locking Jaw  
 Sensitive tooth, teeth or gums.  Ringing in Ears  Bad breath  
 Blisters/Sores in or around the mouth.  Broken/Chipped tooth  
 Other: \_\_\_\_\_  
 Do you require pre-medication?  Yes  No  Don't know  
 Previous Dentist: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Name Phone#  
 Last Dental exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Dental X-rays: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Times a day you brush? \_\_\_\_\_ Times a week you floss? \_\_\_\_\_  
 What type of tooth brush bristles do you use?  Soft  Medium  Hard  
 How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

## MEDICAL HISTORY

**What medications are you taking?**  Nerve pills  Pain killers (including aspirin)  Muscle relaxers  
 Stimulants  Blood Thinners  Tranquilizers  Insulin  Meds for Osteoporosis  
 Other(s), please list: \_\_\_\_\_  
 Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax)  Yes  No Phen-fen/Redux  Yes  No  
**Do you have or have you had any of the following diseases, medical conditions or procedures?**  

<input type="checkbox"/> Heart Attack / Stroke	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Cancer/Tumors	<input type="checkbox"/> Cosmetic Surgery
<input type="checkbox"/> Heart Surg./Pacemaker	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Shingles	<input type="checkbox"/> Xray or Cobalt Treatment
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> HIV+/AIDS/ARC	<input type="checkbox"/> Asthma
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Arthritis/ Rheumatism	<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Artificial Valves	<input type="checkbox"/> Stomach Problems/Ulcers	<input type="checkbox"/> Artificial Bones/Joints	<input type="checkbox"/> Diabetes/Hypoglycemia
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Psychiatric Problems	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Leukemia
<input type="checkbox"/> Congenital Heart Defect	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Fainting/Seizures/Epilepsy	<input type="checkbox"/> Anemia
<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Alcohol/Drug Abuse	<input type="checkbox"/> Severe/Frequent Headaches	<input type="checkbox"/> High/Low Blood Pressure
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Tuberculosis TB	<input type="checkbox"/> Frequent Neck Pain	<input type="checkbox"/> Bleeding Problems
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Jaw Problems TMJ/TMD	<input type="checkbox"/> Back Problems	<input type="checkbox"/> Glaucoma

  
 Please list any other surgeries or medical conditions you have or ever had: \_\_\_\_\_  
 Are you allergic to any of the following?  Latex  Penicillin / Amoxicillin  Tetracycline  Aspirin  
 Dental Anesthetics  Foods: \_\_\_\_\_  Others: \_\_\_\_\_  
 Do you use tobacco?  No  Yes/How used? \_\_\_\_\_ How much? \_\_\_\_\_ How long? \_\_\_\_\_  
 Please rate your general health from 1-10: \_\_\_\_\_ Do you wear contact lenses?  Yes  No  
**For women:** Are you taking Birth Control pills?  Yes  No How many children have you had? \_\_\_\_\_  
 Are you Pregnant?  No  Yes/How long? \_\_\_\_\_ Are you nursing?  Yes  No

- ◆ We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- ◆ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- ◆ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- ◆ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

**I acknowledge that I have received a copy of the Summary of Privacy Notice.**

Initials \_\_\_\_\_

Signature \_\_\_\_\_

Adult Patient  Parent or Guardian  Spouse

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

UPDATE  
(OFFICE USE)

Initials \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Comments \_\_\_\_\_

Initials \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Comments \_\_\_\_\_

Initials \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Comments \_\_\_\_\_

