

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. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

Patient Information

Name _____ Soc. Sec.# _____
Last Name First Name Initial
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Email _____
Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced
Patient Employed by _____ Occupation _____ Business Phone _____
Business Address _____ Business Email _____
Whom may we thank for referring you? _____
Notify in case of emergency _____ Home Phone _____
Cell Phone _____ Business Phone _____ Email _____

Primary Insurance

Person Responsible for Account _____ Soc. Sec.# _____
Last Name First Name Initial
Birthdate _____ Relation to Patient _____
Address (if different from patient) _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Email _____
Person Responsible Employed by _____ Occupation _____ Business Phone _____
Business Address _____ Business Email _____
Insurance Company _____ Contract # _____ Group # _____ Subscriber # _____
Insurance Phone _____ Insurance Email _____
Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? Yes No
Subscriber Name _____ Soc. Sec. # _____
Last Name First Name Initial
Birthdate _____ Relation to Patient _____
Address (if different from patient) _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Email _____
Subscriber Employed by _____ Business Phone _____ Business Email _____
Insurance Company _____ Contract # _____ Group # _____ Subscriber # _____
Insurance Phone _____ Insurance Email _____
Name of other dependents under this plan _____

Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____
 Former Dentist _____ Address _____ Phone _____
 Dentist's Email _____
 Date of last dental care _____ Date of last X-rays _____

Check Y for yes or N for no if you have/have not had the following:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Bad breath | <input type="checkbox"/> Y <input type="checkbox"/> N Food collection between teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Periodontal treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding gums | <input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to cold | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting |
| <input type="checkbox"/> Y <input type="checkbox"/> N Clicking or popping jaw | <input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth or broken fillings | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to hot | <input type="checkbox"/> Y <input type="checkbox"/> N 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 experienced an adverse reaction during or in conjunction with a medical or dental procedure? Y N

Medical History

Physician's name _____ Address _____ Phone _____
 Physician's Email _____

Date of last visit _____ Have you had any serious illnesses or operations? Y N If yes, describe _____
 Y N If yes, describe _____

Are you currently under physician care?

Have you ever had a blood transfusion? Y N If yes, give approximate dates _____

Have you ever taken Fen-Phen/Redux? Y N

Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Check (✓) whether you have had or currently have any of the following:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive | <input type="checkbox"/> Y <input type="checkbox"/> N Cortisone treatments | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N Seizures |
| <input type="checkbox"/> Y <input type="checkbox"/> N Alcohol/Drug Abuse | <input type="checkbox"/> Y <input type="checkbox"/> N Cough, persistent | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis | <input type="checkbox"/> Y <input type="checkbox"/> N Cough up blood | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw pain | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease | <input type="checkbox"/> Y <input type="checkbox"/> N Skin rash |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis, Rheumatism | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney or malfunction | <input type="checkbox"/> Y <input type="checkbox"/> N Spina bifida |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting | <input type="checkbox"/> Y <input type="checkbox"/> N Liver disease | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial joints | <input type="checkbox"/> Y <input type="checkbox"/> N Food allergies | <input type="checkbox"/> Y <input type="checkbox"/> N Material allergies (latex, wool, metal, chemicals) | <input type="checkbox"/> Y <input type="checkbox"/> N Surgical implant |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse | <input type="checkbox"/> Y <input type="checkbox"/> N Swelling of feet or ankles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Atopic (allergy prone) | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Nervous problems | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Back problems | <input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker/Heart surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Tobacco habit |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood disease | <input type="checkbox"/> Y <input type="checkbox"/> N Heart problems | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric care | <input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/
Describe _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Rapid weight gain or loss | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemical dependency | <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/Colitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cholesterol problems | <input type="checkbox"/> Y <input type="checkbox"/> N Hereditary Problems | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet fever | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Circulatory problems | | | |

List medications you are currently taking, if any: _____

List drug allergies, if any: _____

Authorization

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 doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor.

I authorize my insurance company to pay to the doctor or medical group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

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