

Date: _____

Welcome

Thank you for your visit. We appreciate you trusting us to care for your dental health, and pleased to welcome you to our practice. To help us serve you better, please take a few moments to fill out the following forms 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

Name _____ Social Security # _____
Address _____ City _____ State _____ ZIP _____
Home Phone _____ Cell phone _____
e-mail _____ Sex Male Female Age _____ Birthdate _____
Marital Status Single Married Widowed Divorced Separated
Business address _____ Work phone _____
Whom may we thank for referring you? _____
Whom may we notify in case of emergency? _____ Phone _____

Primary Insurance

Member Name _____
Relation to patient _____ Birthdate _____ Social Security # _____
Address (If different from pt.) _____ Phone _____
City _____ State _____ ZIP _____
Employed by _____ Occupation _____
Business address _____ Work phone _____
Insurance Company _____
Contract # _____ Group _____ Subscriber # _____

Dental History

Reason for today's visit _____
Previous dentist _____ Address _____
Date of last dental visit _____ Last dental x rays _____

Please check if you have had 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 collects between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in the mouth |

How often do you floss? _____

Are you happy with your smile? **YES / NO** If **NO**, explain: _____

Medical History

Physician's name _____

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 _____

Are you pregnant? Yes No Are you 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 | <input type="checkbox"/> 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 _____

Authorizations

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. I understand that if I want to get an estimate of my insurance coverage I may request a pre authorization of services.

I understand that notice at least 24 hours prior to your appointment is required for any cancellations with a general dentist. I also understand that notice at least 48 hours prior to the appointment will be required when scheduled with one of the specialists.

I understand that I will be charged a fee for any appointment cancelled or rescheduled within 24 hours.

Signature _____ Date _____