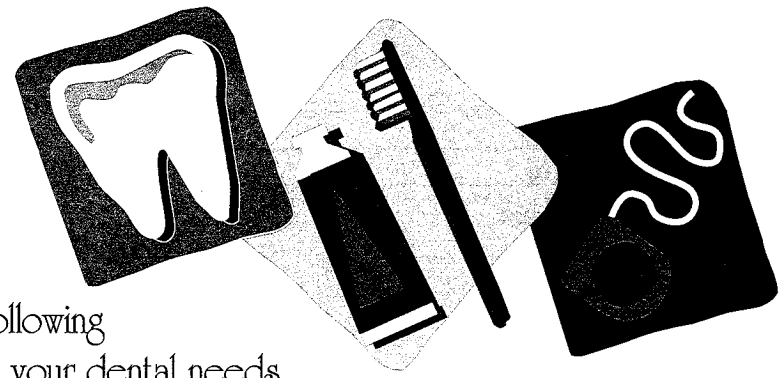
WELCOME
TO OUR PRACTICE!



Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

PATIENT INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____ Home Phone _____
Last Name First Name Initial

Address _____ Cell Phone _____

City _____ State _____ Zip _____ E-mail _____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

PRIMARY DENTAL INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

ADDITIONAL INSURANCE

Insured Name _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Please complete reverse side

DENTAL HISTORY

Former Dentist _____ Date of Last X-Rays _____

City, State _____ How Often Do You Floss? _____

Date of Last Dental Visit _____ How Often Do You Brush? _____

Please check all that apply:

Bad Breath ☐	Loose Teeth or Broken Fillings ☐	Sensitivity to Sweets ☐
Bleeding Gums ☐	Orthodontic Treatment ☐	Sensitivity When Biting ☐
Blisters on Lips or Mouth ☐	Pain Around Ear ☐	Frequent Headaches ☐
Finger Nail Biting ☐	Periodontal Treatment ☐	Jaw, Head or Neck Injuries ☐
Grinding Teeth ☐	Sensitivity to Cold ☐	Jaw Difficulty: Clicking and/or Pain ☐
Lip or Cheek Biting ☐	Sensitivity to Heat ☐	Tooth Pain ☐

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illnesses or operations?	☐	☐
3. Are you currently taking any medication?	☐	☐
Please describe: _____		
4. Do you smoke?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Do you wear contact lenses?	☐	☐

7. Have you had any allergic reactions to the following:

	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

8. (Women Only) Are You:

Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Please check all that apply:

AIDS ☐	Emphysema ☐	Pacemaker ☐
Anemia ☐	Epilepsy ☐	Psychiatric Care ☐
Arthritis, Rheumatism ☐	Fainting or Dizziness ☐	Radiation Treatment ☐
Artificial Heart Valves ☐	Glaucoma ☐	Respiratory Disease ☐
Artificial Joints ☐	Headaches ☐	Rheumatic Fever ☐
Asthma ☐	Heart Murmur ☐	Scarlet Fever ☐
Back Problems ☐	Heart Problems ☐	Shortness of Breath ☐
Bleeding abnormally, with extractions or surgery ☐	Hepatitis-Type _____ ☐	Sinus Trouble ☐
	Herpes ☐	Skin Rash ☐
Blood Disease ☐	High Blood Pressure ☐	Stroke ☐
Cancer ☐	HIV Positive ☐	Swelling of Feet/Ankles ☐
Chemical Dependency ☐	Jaundice ☐	Swollen Neck Glands ☐
Chemotherapy ☐	Jaw Pain ☐	Thyroid Problems ☐
Chronic Fatigue Syndrome ☐	Latex Sensitivity ☐	Tonsillitis ☐
Circulatory Problems ☐	Kidney Disease ☐	Tuberculosis ☐
Congenital Heart Lesions ☐	Liver Disease ☐	Tumor or growth on head/neck ☐
Cortisone Treatments ☐	Low Blood Pressure ☐	Ulcer ☐
Cough - persistent or bloody ☐	Mitral Valve Prolapse ☐	Venereal Disease ☐
Diabetes ☐	Nervous Problems ☐	

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____