

PATIENT INFORMATION

Today's Date

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Please Print:

Name: _____ BirthDate: _____
M _____ F _____

Address: _____
_____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____
_____ Cell _____

Do you prefer to receive calls @ Home _____ Work _____ Cell _____
E-Mail Address: _____ Married _____ Single _____

Employer/School _____ **Employer/School**
Phone _____

Employer/School
Address _____ City _____ State _____ Zip _____

Whom may we thank for referring you _____

Emergency Contact _____
Phone _____

INSURANCE INFORMATION

Name of Insured _____ Relationship to
Pt _____

Birthdate _____ Social Security # _____

Name of Employer _____ Employer's
Phone _____

Insurance Company _____ Group # _____

Insurance Co.
Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max Annual
Benefit _____

SECONDARY INSURANCE

Name of Insured _____ Relationship to Pt _____

Birthdate _____ Social Security # _____

Name of Employer _____ Employer's
Phone _____

Insurance Company _____ Group # _____

Insurance Co.
Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max Annual
Benefit _____

DENTAL HISTORY

Former Dentist _____ Date of Last Dental Care

Reason for today's Visit

Date of Last Exam _____ Date of last Dental X-Rays _____

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

Please check any of the following that apply to you:

- | | |
|---|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Bleeding Gums |
| <input type="checkbox"/> Clicking or popping Jaw | <input type="checkbox"/> Food Collection Between Teeth |
| <input type="checkbox"/> Grinding/Clenching teeth | <input type="checkbox"/> Loose Teeth or Broken Fillings |
| <input type="checkbox"/> Loose teeth or Broken fillings | <input type="checkbox"/> Sensitivity to HOT/COLD |
| <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Sensitivity to Sweets |
| <input type="checkbox"/> Sores or growths in your mouth | <input type="checkbox"/> Sensitivity to Biting/Pressure |

MEDICAL HISTORY

Physician's Name _____ Date of last
visit _____

Allergies

Women: Are you Pregnant? Yes No Nursing? Yes No Taking Birth Control Pills?
Yes No

Circle if you **have** or **have a history** of any of the following:

Abnormal Bleeding	Alcohol Abuse	Anemia	Angina Pectoris	Arthritis
Artificial Heart Valve	Artificial Joints	Asthma	Back Problems	Blood Thinners
Blood Transfusion Persistent	Cancer-Chemotherapy	Cough up blood	Chemical Dependency	Cough,

Diabetes	Difficulty Breathing	Drug Abuse	Emphysema	Epilepsy
Fever Blisters	HIV+AIDS	Heart Attack	Heart defect-congenital	Heart Murmur
Hemophilia	Hepatitis A	Hepatitis B	Hepatitis C	High Blood Pressure
Kidney Problems	Liver Disease	Low Blood Pressure	Mitral Valve Prolapse	Pace Maker
Pain in Jaw Joints	Radiation Therapy	Rheumatic Fever	Seizures	
Street/Recreational Drug				
Stroke	Thyroid Problems	Tobacco Habit	Tuberculosis	Ulcers
Glaucoma	Respiratory Disease	Sinus Problems	Circulatory Problems	
Other _____				

List All Medications _____

AUTHORIZATION I certify that I have read and understand to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information to third party payors. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. 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 or my dependents.

X _____

Signature of Patient (or Parent if a Minor)

DATE