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PATIENT INFORMATION

Patient Name: _____ Name you prefer to be called: _____
First MI Last

Patient Address: _____ City: _____ State: _____ Zip: _____

Patient Home # _____ Work # _____ Cell # _____ Patient SS#: _____

Patient Birthdate: _____ Patient Age: _____ Are you? Male Female Married Single

E-mail address: _____ Appt. Confirmation by Text Messaging? Yes _____ No _____

Wireless Provider: _____

Spouse Name: _____ Spouse Employer: _____

If patient is a student please answer the following questions:

Mother's Name _____ Mother's Employer _____

Father's Name _____ Father's Employer _____

Name of person/s with whom you live: _____ Relationship: _____

Person to contact in case of emergency: _____ Phone # _____

Patient's Employer: _____ Whom may we thank for referring you to us? _____

Patient's Occupation: _____ Other family members seen in this office? _____

Work Phone #: _____

RESPONSIBLE PARTY

Name of person responsible for this account: _____ Relationship to patient: _____

Birthdate of Responsible person: _____ SSN of Responsible Person: _____

Address of Responsible Person: _____ City _____ State: _____ Zip: _____

DENTAL INSURANCE INFORMATION

Name of Insured: _____ Relationship to Patient: _____

Birthdate of Insured: _____ Social Security # of Insured: _____ ID# _____

Name of Employer: _____ Work Phone # _____

Address of Employer: _____ City _____ State: _____ Zip: _____

Insurance Co: _____ Group # _____

Have you used your dental benefits at another office? _____

DENTAL HISTORY

Former Dentist _____ Date of Last Exam _____

Are you happy with your smile? _____ If not, what would you change? _____

Please check any of the following conditions that apply to you:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <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 collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

MEDICAL HISTORY

Physician: _____ Date of last visit _____

Please list **all** medications that you are currently taking: _____

Women: Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Do you have a history of the following?

- | | | | | | |
|--|--|--|--|--|--|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Cancer | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Lupus | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Alcohol/ Drug Abuse | <input type="checkbox"/> Chemotherapy/Radiation | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Herpes | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Steroid Therapy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Bones/Joints | <input type="checkbox"/> Colitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Artificial Valves | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Hospitalized | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Headaches | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Shingles | <input type="checkbox"/> Venereal Disease |

Other conditions: _____

Allergies: Aspirin Dental Anesthetics Latex Sulfa Drugs
Barbiturates Erythromycin Penicillin Tetracycline
Codeine Jewelry/Metals Sedatives Other _____

Acknowledgement of Receipt of Notice of Privacy Practices *You May Refuse to Sign This Acknowledgement*

I have been offered a copy of this office's Notice of Privacy Practice. Signature _____

Authorization

I certify that I have read and understand the above information 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 including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. 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