



Welcome to Our Practice!

Thank You for trusting us with your dental care.
We promise to do our best to provide you with the finest
care available. If you have any questions please do not
hesitate to contact us.

Patient #: _____

SS#: _____

Date of Birth: _____

PATIENT INFORMATION

Patient's Name

Last: _____ First: _____ Middle: _____ Male: Female:

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

Home Phone: () - E-mail: _____

Check Appropriate Box: Minor: Single: Married: Divorced: Widowed: Separated:

Patient's or Parent's Employer: _____ Work Phone: () -

Business Address: _____ City _____ State _____ Zip _____

Spouse or Parent's Name: _____ Employer: _____ Work Phone: () -

If Patient is a Student, Name of School/College: _____ City: _____ State: _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency: _____ Phone: () -

RESPONSIBLE PARTY

Name of Person Responsible for this Account

Last: _____ First: _____ Middle: _____ Male: Female:

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

Home Phone: () - E-mail: _____ Birthdate: _____

Driver's License # _____ Social Security # _____ Bank: _____

Employer: _____ Work Phone: () -

Currently a Patient in our Office? Yes: No:

INSURANCE INFORMATION

Name of Insured

Last: _____ First: _____ Middle: _____ Male: Female:

Relation to Patient: _____ Birthdate: _____ Soc. Security #: _____

Employer: _____ Work Phone: () - Date Employed: _____

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

Insurance Company: _____ Group: _____ Union or Local #: _____

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

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit: _____

ADDITIONAL INSURANCE

Name of Insured

Last: _____ First: _____ Middle: _____ Male: Female:

Relation to Patient: _____ Birthdate: _____ Soc. Security #: _____

Employer: _____ Work Phone: () - Date Employed: _____

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

Insurance Company: _____ Group: _____ Union or Local #: _____

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

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit: _____

Reason for today's visit _____ Date of last dental visit _____
Former Dentist _____ Date of last dental X-rays _____
Address _____

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 collection between the teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in you mouth |

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

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to a "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).

Yes No

Have you had any serious illnesses or operations? Yes No If yes, describe _____

Have you ever had a blood transfussion? Yes No If yes, give approximate dates _____

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

Check (√) if you have had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Preasure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |

Medications:

List medications you are currently taking and the correlating diagnosis: _____

Allergies:

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. 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. I authorize the use of this signature on all insurance submissions.

Signature of patient or parent if minor _____ Date _____

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