



*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 call us.*

Patient # \_\_\_\_\_  
 SS # \_\_\_\_\_  
 Date \_\_\_\_\_

## PATIENT INFORMATION

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 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 \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
 Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Driver's License # \_\_\_\_\_ Birthdate \_\_\_\_\_ Bank \_\_\_\_\_  
 Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Currently a Patient in our Office?  Yes  No

## INSURANCE INFORMATION

Name of Insured \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_  
 Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 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 \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_  
 Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 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 \_\_\_\_\_

**OVER**

## DENTAL HISTORY

Reason for today's visit \_\_\_\_\_

Former Dentist \_\_\_\_\_

Address \_\_\_\_\_

Date of last dental visit \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_

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 your mouth |

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

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

Have you ever had a blood transfusion?  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"/> 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            | 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           |

## MEDICATIONS

List medications you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_

## ALLERGIES

## AUTHORIZATION AND RELEASE

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.**