

# Welcome!

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 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 # \_\_\_\_\_



# 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 ..... ☐  
 Bleeding Gums ..... ☐  
 Blisters on Lips or Mouth ..... ☐  
 Finger Nail Biting ..... ☐  
 Grinding Teeth ..... ☐  
 Lip or Cheek Biting ..... ☐

Loose Teeth or Broken Fillings ..... ☐  
 Orthodontic Treatment ..... ☐  
 Pain Around Ear ..... ☐  
 Periodontal Treatment ..... ☐  
 Sensitivity to Cold ..... ☐  
 Sensitivity to Heat ..... ☐

Sensitivity to Sweets ..... ☐  
 Sensitivity When Biting ..... ☐  
 Frequent Headaches ..... ☐  
 Jaw, Head or Neck Injuries ..... ☐  
 Jaw Difficulty: Clicking and/or Pain.. ☐  
 Tooth Pain ..... ☐

# Medical History

Physician's Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Are you currently under medical treatment? .....             | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had any serious illnesses or operations? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any medication? .....               | <input type="checkbox"/> | <input type="checkbox"/> |

Please describe: \_\_\_\_\_  
 \_\_\_\_\_

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 4. Do you smoke? .....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use alcohol, cocaine or other drugs? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you wear contact lenses? .....                 | <input type="checkbox"/> | <input type="checkbox"/> |

Please check all that apply:

AIDS ..... ☐  
 Anemia..... ☐  
 Arthritis, Rheumatism ..... ☐  
 Artificial Heart Valves ..... ☐  
 Artificial Joints ..... ☐  
 Asthma ..... ☐  
 Back Problems ..... ☐  
 Bleeding abnormally, with extractions or surgery ..... ☐  
 Blood Disease ..... ☐  
 Cancer ..... ☐  
 Chemical Dependency ..... ☐  
 Chemotherapy ..... ☐  
 Chronic Fatigue Syndrome ..... ☐  
 Circulatory Problems ..... ☐  
 Congenital Heart Lesions..... ☐  
 Cortisone Treatments ..... ☐  
 Cough - persistent or bloody.... ☐  
 Diabetes..... ☐

Emphysema ..... ☐  
 Epilepsy ..... ☐  
 Fainting or Dizziness ..... ☐  
 Glaucoma ..... ☐  
 Headaches..... ☐  
 Heart Murmur ..... ☐  
 Heart Problems..... ☐  
 Hepatitis-Type ..... ☐  
 Herpes..... ☐  
 High Blood Pressure ..... ☐  
 HIV Positive ..... ☐  
 Jaundice ..... ☐  
 Jaw Pain ..... ☐  
 Kidney Disease ..... ☐  
 Latex Sensitivity ..... ☐  
 Liver Disease..... ☐  
 Low Blood Pressure ..... ☐  
 Mitral Valve Prolapse..... ☐  
 Nervous Problems..... ☐

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

	Yes	No
Local Anesthetics (eg. novocaine) .....	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other Antibiotics .....	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa Drugs .....	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates (sleeping pills) .....	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives .....	<input type="checkbox"/>	<input type="checkbox"/>
Iodine .....	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin .....	<input type="checkbox"/>	<input type="checkbox"/>
Other .....	<input type="checkbox"/>	<input type="checkbox"/>

8. (Women Only) Are You:

Pregnant? .....	<input type="checkbox"/>	<input type="checkbox"/>
Nursing? .....	<input type="checkbox"/>	<input type="checkbox"/>
Taking birth control pills? .....	<input type="checkbox"/>	<input type="checkbox"/>

Pacemaker..... ☐  
 Psychiatric Care ..... ☐  
 Radiation Treatment..... ☐  
 Respiratory Disease..... ☐  
 Rheumatic Fever ..... ☐  
 Scarlet Fever ..... ☐  
 Shortness of Breath ..... ☐  
 Sinus Trouble..... ☐  
 Skin Rash ..... ☐  
 Stroke ..... ☐  
 Swelling of Feet/Ankles..... ☐  
 Swollen Neck Glands..... ☐  
 Thyroid Problems..... ☐  
 Tonsillitis ..... ☐  
 Tuberculosis..... ☐  
 Tumor or growth on head/neck..... ☐  
 Ulcer..... ☐  
 Venereal Disease ..... ☐

# 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 \_\_\_\_\_