Welcome

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Thank you for selecting our dental health care team! We will strive to provide you with the best possible dental care. To help us meet your dental health care needs, please fill out this form completely. If you have any questions or need assistance, please ask us- we will be happy to help.

Patient Information

Today's Date:_____

Patient Name:_____ Birth Date:_____
First Middle Int. Last

If Patient is a child/minor, Parent Name(s):_____

Please circle one: Male/Female Please circle one: Married/ Single/ Widow/ Child/ Other

Social Security #:_____ (This is confidential and is used for billing purposes only.)

Phone (Home):_____ (Cell):_____ (Work):_____

E-Mail:_____ Would you like to receive our monthly newsletter? Y or N

Address: _____
Street Apartment/Unit #

_____
City State Zip Code

Are you a student: Y or N If yes, name of School/College:_____

Who may we thank for referring you to our practice? Yellow Pages, Internet, Newspaper, Insurance Company, Friend/Relative that is a patient of our practice (Name)_____

Health Information

Drug Allergies:_____ Any other Allergies:_____

Have you every had any of the following? Please check those that apply:

___ Anemia
___ Artificial Joints
___ Asthma
___ Blood Disease or Bleeding
___ Cancer
___ Diabetes
___ Epilepsy
___ Fainting
___ Heart Disease
___ Heart Murmur
___ High Blood Pressure
___ HIV+
___ Kidney Disease
___ Liver Disease/Hepatitis
___ Mental (Nervous)
___ Radiation Treatment
___ Respiratory Problems
___ Rheumatic Fever
___ Stroke
___ Tuberculosis
___ Codeine Allergy
___ Penicillin Allergy

Do you use Tobacco Products? Y or N

Women: Are you Pregnant? Y or N
If yes, due date:_____

What Medications are you taking at this time?_____

_____

_____

Over Please

Name of Physician:_____ Phone:_____

Are you currently under the care of a physician for reasons other than routine care? Yes or No

If yes please explain:_____

Responsible Party Information

Person Responsible for Account:_____

Relationship to Patient:_____ Birth Date:_____

Social Security #: _____ (This is confidential and is used for billing purposes only.)

Address: _____
Street Apartment/Unit #

_____
City State Zip Code

Phone (Home):_____ (Cell):_____ (Work):_____

Is Patient covered by Dental Insurance: Y or N If yes, is Insurance through an employer: Y or N

If Yes, Employer Name: _____

Insurance Company Name & Phone #:_____

Policy/ID #_____ Group #_____ Do you have additional Insurance? Y or N

Patient Dental History

Name & location of Previous Dentist:_____

Date of last dental visit:_____ Reason for visit:_____

Do your gums bleed while brushing or flossing?	Y or N	Have you had any orthodontic treatment?	Y or N
Are your teeth sensitive to hot/cold liquids/food?	Y or N	Do you wear dentures or partials?	Y or N
Do you feel pain to any of your teeth?	Y or N	Do you experience the following jaw problems?	
Do you have any sores/lumps in/near mouth?	Y or N	Clicking?	Y or N
Have you had any head, neck, jaw injuries?	Y or N	Pain (joine, ear, side of face)?	Y or N
Do you have frequent headaches?	Y or N	Difficulty opening or closing?	Y or N
Do you clench or grind your teeth?	Y or N	Are you happy with your smile?	Y or N
Do you bite your cheek or lips frequently?	Y or N	If no, why?_____	

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge and that the above questions have been answered accurately. I understand that providing incorrect information can be dangerous to my health. If there are changes in my health I will notify the doctor at, or before my next appointment. I authorize and request my insurance company to pay directly to the dentist unless contrary to my insurance contract. 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 behalf of myself and/or my dependent. I understand that a service charge of 1 ½% per month (18% per year) will be added to any unpaid balances exceeding 30 days, unless prior financial arrangements are made.

_____
Signature of Patient, Parent or Guardian Date Relationship to Patient