

# WELCOME



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## PATIENT INFORMATION

Patient \_\_\_\_\_ Date \_\_\_\_\_

Home Address \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex:  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Married  Single  Divorced  Separated  Widowed

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

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

Employer's Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

Occupation \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Spouse's Employer Address \_\_\_\_\_

Spouse's Employer Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## DENTAL INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

If yes, Insurance Co. \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS # \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party's Signature \_\_\_\_\_

Relationship \_\_\_\_\_ Date \_\_\_\_\_

## PHONE NUMBERS

Home \_\_\_\_\_ Work \_\_\_\_\_ Ext. \_\_\_\_\_ Cell \_\_\_\_\_ Spouse's Work \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_ Email: \_\_\_\_\_

### EMERGENCY CONTACT: (Specify someone who does not live in your household.)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

## DENTAL HISTORY

Please mark "Yes" or "No" to indicate if you have or had any of the following:

Reason for today's visit _____	Bad taste <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth or broken filling <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental x-rays _____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
If you had a magic wand, what would you change about your teeth?	Cigarette, pipe or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold/heat/sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Dark teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Unightly teeth <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Food collection between teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
_____	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____
_____	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	

# HEALTH HISTORY

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

Physician's Address \_\_\_\_\_

Please mark "Yes" or "No" to indicate if you have or had any of the following:

AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prosthetic Replacement	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcohol use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy/Seizures or Convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric Treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fainting or Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Angina/Chest Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fever Blisters/Mouth Ulcers or Canker Sores	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Joint	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hearing Problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Back Problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding abnormally, w/ extractions or surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke/TIA	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swelling of Feet or Ankles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	HIV+	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tobacco use	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Circulatory Problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tumor/Growth on Head/Neck	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cirrhosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congenital Heart Lesion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Leukemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vision Problem/Glaucoma or Cataract	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Women:		
Dialysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nervous Problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drug/Alcohol rehabilitation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Due date _____		
Drug use (illegal)	<input type="checkbox"/> Yes	<input type="checkbox"/> No				Are you nursing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

## MEDICATIONS

List medications you are currently taking \_\_\_\_\_

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

List Past surgeries \_\_\_\_\_

Pharmacy's Name \_\_\_\_\_ Ph: \_\_\_\_\_

## ALLERGIES

(Causing swelling, rash, hives, itching or difficulty breathing)

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Barbiturates (Sleeping pills)	<input type="checkbox"/> Penicillin or other antibiotics
<input type="checkbox"/> Codeine or other pain meds	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other Drugs _____
<input type="checkbox"/> Latex	_____

I CONSENT TO TREATMENT AS NECESSARY OR DESIRABLE TO THE CARE OF THE PATIENT FIRST NAMED ABOVE, INCLUDING BUT NOT LIMITED TO WHATEVER DRUGS, MEDICINE, PERFORMANCE OF OPERATIONS, AND CONDUCT OF LABORATORY, X-RAY OR OTHER STUDIES THAT MAY BE USED BY THE ATTENDING DOCTOR OR QUALIFIED DESIGNATE. I ALSO ACKNOWLEDGE FULL RESPONSIBILITY FOR THE PAYMENT OF SUCH SERVICES AND AGREE TO PAY THEM IN FULL AT THE TIME OF SERVICE. I ACKNOWLEDGE THAT IT IS MY RESPONSIBILITY AND NOT AN INSURANCE COMPANY TO PAY FOR ANY OR ALL SERVICES. ANY OUTSTANDING BALANCE AFTER 30 DAYS MAY INCUR A FINANCE CHARGE OF 18% PER ANNUM OR 1-1/2% PER MONTH.

Signed \_\_\_\_\_ Patient, Parent or Guardian (Must be 18 years or older) \_\_\_\_\_ Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

## OFFICE USE

BLOOD PRESSURE \_\_\_\_\_

PULSE \_\_\_\_\_

NOTES: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_