

# WELCOME

## 1 ABOUT YOU

Today's Date: \_\_\_ / \_\_\_ / \_\_\_ File #. \_\_\_

Patient Name: \_\_\_\_\_  
LAST FIRST MI

What You Prefer To Be Called: \_\_\_\_\_  Male  Female

Birthdate: \_\_\_ / \_\_\_ / \_\_\_ Age: \_\_\_ SS#: \_\_\_

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

\_\_\_\_\_ CITY STATE ZIP

Home Phone #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Ext: \_\_\_\_\_

Other Phone #s: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Referred By: \_\_\_\_\_

Employer: \_\_\_\_\_ How Long? \_\_\_\_\_

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

\_\_\_\_\_ CITY STATE ZIP

Occupation: \_\_\_\_\_

Status:  Minor  Single  Married  Divorced  Separated  Widowed

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

Do you have children?  Yes  No How many? \_\_\_\_\_

## 2 INSURANCE INFO

Primary Dental Insurance

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ CITY STATE ZIP

Phone #: \_\_\_\_\_

Insured's SS#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_ / \_\_\_ / \_\_\_

Insured's Employer: \_\_\_\_\_

Secondary Dental Insurance

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ CITY STATE ZIP

Phone #: \_\_\_\_\_

Insured's SS#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_ / \_\_\_ / \_\_\_

Insured's Employer: \_\_\_\_\_

## 3 ACCOUNT INFO

Person ultimately responsible for account

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Billing Address: \_\_\_\_\_

\_\_\_\_\_ CITY STATE ZIP

SS #: \_\_\_\_\_

Drivers License #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_

Payment method:  Cash  Check

Credit Card - Enter card # above (# accepted)

I hereby authorize assignment of my insurance  
inside rights and benefits directly to the provider for  
services rendered. I fully understand I am solely responsi-  
ble for any balance not paid by my insurance company  
(if offered at this office).

## 4 IN EVENT OF EMERGENCY

Who should we contact? \_\_\_\_\_

Relation: \_\_\_\_\_

Home Phone #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_

Who is your Medical Doctor? \_\_\_\_\_

M.D.'s Phone #: \_\_\_\_\_

Reason for today's visit:  Exam  Emergency  ConsultationAre you in pain?  No  Yes How Long? \_\_\_\_\_Please indicate  any of the following problems: Discomfort, clicking or popping in jaw.  Lost/Broken Filling(s)  Stained teeth Red, swollen or bleeding gums.  Teeth grinding  Locking Jaw Sensitive tooth, teeth or gums.  Ringing in Ears  Bad breath Blisters/Sores in or around the mouth.  Broken/Chipped tooth Other: \_\_\_\_\_Do you require pre-medication?  Yes  No  Don't knowPrevious Dentist: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Name Phone

Last Dental exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Dental X-rays: \_\_\_\_/\_\_\_\_/\_\_\_\_

Times a day you brush? \_\_\_\_\_ Times a week you floss? \_\_\_\_\_

What type of tooth brush bristles do you use?  Soft  Medium  Hard

How would you rate your smile? (circle 1 2 3 4 5 6 7 8 9 10 Best)

## MEDICAL HISTORY

Are you taking any of the following medications?  Nerve pills  Pain killers (including aspirin) Muscle relaxers  Stimulants  Blood Thinners  Tranquilizers  Insulin Other(s), please list: \_\_\_\_\_

Do you have or have you had any of the following diseases, medical conditions or procedures?

<input type="checkbox"/> Heart Attack / Stroke	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Cancer/Tumors	<input type="checkbox"/> Cosmetic Surgery
<input type="checkbox"/> Heart Surg./Pacemaker	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Shingles	<input type="checkbox"/> Xray or Cobalt Treatment
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> HIV/AIDS/ARC	<input type="checkbox"/> Asthma
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Arthritis/ Rheumatism	<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Artificial Valves	<input type="checkbox"/> Stomach Problems/Ulcers	<input type="checkbox"/> Artificial Bones/Joints	<input type="checkbox"/> Diabetes/hypoglycemia
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Psychiatric Problems	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Leukemia
<input type="checkbox"/> Congenital Heart Defect	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Fainting/Seizures/Epilepsy	<input type="checkbox"/> Anemia
<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Alcohol/Drug Abuse	<input type="checkbox"/> Severe/Frequent Headaches	<input type="checkbox"/> High/Low Blood Pressure
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Tuberculosis TB	<input type="checkbox"/> Frequent Neck Pain	<input type="checkbox"/> Bleeding Problems
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Jaw Problems TMJ/TMD	<input type="checkbox"/> Back Problems	<input type="checkbox"/> Glaucoma

Please list any other medical condition(s) you have or ever had: \_\_\_\_\_

Are you allergic to any of the following?  Latex  Penicillin / Amoxicillin  Tetracycline  Aspirin Dental Anesthetics  Others: \_\_\_\_\_Do you use tobacco?  No  Yes/How used? \_\_\_\_\_ How much? \_\_\_\_\_ How long? \_\_\_\_\_Please rate your general health from 1-10: \_\_\_\_\_ Do you wear contact lenses?  Yes  NoHave you ever taken the drug Phin-fen and or Redux?  Yes  NoFor women: Are you taking Birth Control pills?  Yes  No How many children have you had? \_\_\_\_\_Are you Pregnant?  No  Yes/How long? \_\_\_\_\_ Are you nursing?  Yes  No

We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

 Adult Patient  Parent or Guardian  SpouseUPDATE  
(OFFICE USE)

Initials \_\_\_\_\_ Date \_\_\_\_\_

Comments \_\_\_\_\_

Initials \_\_\_\_\_ Date \_\_\_\_\_

Comments \_\_\_\_\_

Initials \_\_\_\_\_ Date \_\_\_\_\_

Comments \_\_\_\_\_