

Implant | Cosmetic | Restorative | Dentistry

**WELCOME**

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

**PATIENT INFORMATION**

Name _____	Soc. Sec. # _____
<i>Last Name</i> _____	<i>First Name</i> _____
<i>Initial</i> _____	
Address _____	Personal email _____
City _____	State _____ Zip _____ Home Phone _____
Cell Phone _____	Driver's License # _____
Sex <input type="checkbox"/> M <input type="checkbox"/> F Age _____	Birthdate _____ <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced
Employer _____	Occupation _____
Business Phone _____	Business Email _____
Business Address _____	
Whom may we thank for referring you? _____	
Notify in case of emergency _____	Home Phone _____
Cell Phone _____	Business Phone _____

**PRIMARY INSURANCE**

Person Responsible for Account _____	<i>Last Name</i> _____	<i>First Name</i> _____	<i>Initial</i> _____
Relation to Patient _____	Birthdate _____	Soc. Sec. # _____	
Address (if different from patient) _____	Home Phone _____		
Cell Phone _____	Email _____		
City _____	State _____	Zip _____	
Person Responsible Employed by _____	Occupation _____		
Business Address _____	Business Phone _____		
Business Email _____			
Insurance Company _____	Phone _____		
Contract # _____	Group # _____	Subscriber # _____	
Name of other dependents on this plan _____			

**ADDITIONAL INSURANCE**

Is patient covered by additional insurance? <input type="checkbox"/> Y <input type="checkbox"/> N			
Subscriber Name _____	Relation to Patient _____	Birthdate _____	
Address (if different from patient) _____	Soc. Sec. # _____		
City _____	State _____	Zip _____	Home Phone _____
Cell Phone _____	Email _____		
Subscriber Employed by _____	Business Phone _____		
Business Email _____			
Insurance Company _____	Phone _____		
Contract # _____	Group # _____	Subscriber # _____	
Name of other dependents under this plan _____			

**DENTAL HISTORY**

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What would you like us to do today? \_\_\_\_\_

Are you in discomfort? \_\_\_\_\_

Former Dentist \_\_\_\_\_ Phone \_\_\_\_\_ Address \_\_\_\_\_

Date of last dental care \_\_\_\_\_ Date of last x-rays \_\_\_\_\_

Check (  ) yes or no if you have had problems with any of the following:

Y  N Bad breath       Y  N Food collection between teeth       Y  N Periodontal treatment       Y  N Sensitivity to sweets

Y  N Bleeding gums       Y  N Grinding or clenching teeth       Y  N Sensitivity to cold       Y  N Sensitivity when biting

Y  N Clicking or popping jaw       Y  N Loose teeth or broken fillings       Y  N Sensitivity to hot       Y  N Sores or growths in mouth

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

How do you feel about the appearance of your teeth? \_\_\_\_\_

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?  Y  N

**MEDICAL HISTORY**

Physician's name \_\_\_\_\_ Phone \_\_\_\_\_

Date of last visit \_\_\_\_\_ Have you had any serious illnesses or operations, including a blood transfusion?  Y  N

Are you currently under physician care?  Y  N If yes, describe \_\_\_\_\_  
Approximate dates \_\_\_\_\_

Are you currently taking any medication or drugs?  Y  N If yes, please list \_\_\_\_\_

Have you taken any medication during the past two years including appetite suppressants – fen-phen (fenfluramine & phentermine) or dexfenfluramine or fenfluramine?  
 Y  N If yes, please list \_\_\_\_\_ Date \_\_\_\_\_

Do you have any drug allergies?  Y  N If yes, list all \_\_\_\_\_

**Women:** Are you pregnant?  Y  N    Nursing?  Y  N    Taking birth control pills?  Y  N

Check (  ) yes or no whether you have had any of the following:

<input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive	<input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur	<input type="checkbox"/> Y <input type="checkbox"/> N Radiation treatment
<input type="checkbox"/> Y <input type="checkbox"/> N Allergies or hives	<input type="checkbox"/> Y <input type="checkbox"/> N Circulatory problems	<input type="checkbox"/> Y <input type="checkbox"/> N Heart problems	<input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease
<input type="checkbox"/> Y <input type="checkbox"/> N Allergy to latex	<input type="checkbox"/> Y <input type="checkbox"/> N Cold sores/Herpes	<input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/Abnormal bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic / Scarlet fever
<input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis	<input type="checkbox"/> Y <input type="checkbox"/> N Cough, persistent	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis A (infectious)	<input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath
<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N Cough up blood	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis B (serum)	<input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell disease
<input type="checkbox"/> Y <input type="checkbox"/> N Arteriosclerosis	<input type="checkbox"/> Y <input type="checkbox"/> N Developmentally disabled	<input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure	<input type="checkbox"/> Y <input type="checkbox"/> N Sinus trouble
<input type="checkbox"/> Y <input type="checkbox"/> N Arthritis, Rheumatism	<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease / malfunction	<input type="checkbox"/> Y <input type="checkbox"/> N Spina Bifida
<input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves	<input type="checkbox"/> Y <input type="checkbox"/> N Drug addiction	<input type="checkbox"/> Y <input type="checkbox"/> N Liver disease	<input type="checkbox"/> Y <input type="checkbox"/> N Stroke
<input type="checkbox"/> Y <input type="checkbox"/> N Artificial joints	<input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N Material allergies	<input type="checkbox"/> Y <input type="checkbox"/> N Surgical implant
<input type="checkbox"/> Y <input type="checkbox"/> N Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N Fainting	<input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse	<input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease/malfunction
<input type="checkbox"/> Y <input type="checkbox"/> N Blood disease	<input type="checkbox"/> Y <input type="checkbox"/> N Food allergies	<input type="checkbox"/> Y <input type="checkbox"/> N Nervous problems	<input type="checkbox"/> Y <input type="checkbox"/> N Tobacco habit
<input type="checkbox"/> Y <input type="checkbox"/> N Bruise easily	<input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker/Heart surgery	<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis
<input type="checkbox"/> Y <input type="checkbox"/> N Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N Hay fever	<input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric care	<input type="checkbox"/> Y <input type="checkbox"/> N Tumors
<input type="checkbox"/> Y <input type="checkbox"/> N Chemical dependency	<input type="checkbox"/> Y <input type="checkbox"/> N Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N Rapid weight gain or loss	<input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease

**AUTHORIZATION**

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. I understand that it is my responsibility to advise your office of any changes in the information contained on this form. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges.

Patient and/or Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by Dr. \_\_\_\_\_ Date \_\_\_\_\_