WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 About You

Today's Date:_____ E-mail Address:_____

Name:_____
LAST FIRST MI MR. MRS. MS. DR

I prefer to be called:_____ ☐ Male ☐ Female

Birthdate:__/__/__ Age:_____ SS #:_____

Home Address:_____
APT/CONDO #:

_____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (___)_____ Pager/Other #:_____

Wk #: (___)_____ Ext: ___ DL #:_____

Employer:_____

Employer's Address:_____

How long there?_____ Occupation:_____

Where & when are best times to reach you?_____

Whom may we thank for referring you?_____

Other family members seen by us:_____

Previous/Present Dentist:_____
(Please Circle)

Last Visit Date:_____

2 Spouse Information

His/Her Name:_____

Employer:_____

Wk #: (___)_____ Ext:___ SS #:_____

Birthdate:__/__/__ Driver's License #:_____

Person Responsible for Account:

Wk #: (___)_____ Ext.___ Hm #: (___)_____

Billing Address:_____

Relation:_____ SS #:_____

Employer:_____ DL #:_____

3 Insurance Coverage

PRIMARY

Dental Coverage: ☐ Yes ☐ No Medical Coverage: ☐ Yes ☐ No

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone #: (___)_____

Group # (Plan, Local or Policy #):_____

Insured's Name:_____ Relation:_____

Insured's Birthdate:__/__/__ Insured's SS #:_____

Insured's Employer:_____

Name of nearest relative not living with you

His/Her Name:_____ Relation:_____

Address_____

City_____ State_____ Zip_____

Wk #: (___)_____ Hm #: (___)_____

In the event of an emergency, is there someone who lives near you that we should contact?

His/Her Name:_____ Relation:_____

Wk #: (___)_____ Hm #: (___)_____

4 Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician Name:_____

Phone #: (___)_____ Date of last visit:_____

Pharmacy:_____ Phone #: (___)_____

CONTINUED ON BACK

4 Medical History (cont'd)

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Are you taking any prescription/over-the-counter drugs? ☐ Yes ☐ No

Please list each one: _____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

_____

_____

For Women:

Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Yes	No	Abnormal Bleeding	Yes	No	Hepatitis
Yes	No	Alcohol/Drug Abuse	Yes	No	Herpes/Fever Blisters
Yes	No	Anemia	Yes	No	High Blood Pressure
Yes	No	Arthritis	Yes	No	HIV+/AIDS
Yes	No	Artificial Bones/Joints/Valves	Yes	No	Hospitalized for Any Reason
Yes	No	Asthma	Yes	No	Kidney Problems
Yes	No	Blood Transfusion	Yes	No	Liver Disease
Yes	No	Cancer/Chemotherapy	Yes	No	Low Blood Pressure
Yes	No	Colitis	Yes	No	Mitral Valve Prolapse
Yes	No	Congenital Heart Defect	Yes	No	Pacemaker
Yes	No	Diabetes	Yes	No	Psychiatric Problems
Yes	No	Difficulty Breathing	Yes	No	Radiation Treatment
Yes	No	Emphysema	Yes	No	Rheumatic/Scarlet Fever
Yes	No	Epilepsy	Yes	No	Seizures
Yes	No	Fainting Spells	Yes	No	Shingles
Yes	No	Frequent Headaches	Yes	No	Sickle Cell Disease/Traits
Yes	No	Glaucoma	Yes	No	Sinus Problems
Yes	No	Hay Fever	Yes	No	Stroke
Yes	No	Heart Attack	Yes	No	Thyroid Problems
Yes	No	Heart Murmur	Yes	No	Tuberculosis (TB)
Yes	No	Heart Surgery	Yes	No	Ulcers
Yes	No	Hemophilia	Yes	No	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Yes	No	Aspirin	Yes	No	Erythromycin
Yes	No	Codeine	Yes	No	Jewelry
Yes	No	Dental Anesthetics	Yes	No	Latex
Yes	No	Metals			
Yes	No	Penicillin			
Yes	No	Tetracycline			

Please list any other drugs/materials that you are allergic to: _____

_____

5 Dental History

Why have you come to the dentist today?

_____

_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

You current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No

Would you like fresher breath? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

How many times a week do you floss? ____ a day do you brush? ____

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

I

- **authorize use of this form on all my insurance submissions.**
- **authorize release of information to my Insurance Company.**
- **agree to be personally responsible for any unpaid balance or co-payment due, and if I receive any payments from my Insurance Co. in error, I will immediately sign them over to the dentist.**
- **authorize my dentist to act as my agent in helping me obtain payment from my Insurance company.**
- **permit a copy of this authorization to be used in place of the original.**
- **authorize payment directly to the dentist.**

Signature _____ Date _____

Payment is due in full at the time of treatment unless prior arrangements have been approved.

!

I understand that any balance over 30 days may be subject to a service charge of 2.0% per month (24% annually) plus court costs, reasonable attorney fees and possibly collection fees if necessary. I understand that I am responsible for my bill and that insurance claims for service do not alter my responsibility to pay my account within the time allowed by this office's credit policy. I further agree that this contract will remain in force for all services regardless of the date signed. **(There may be a $50.00 charge for any broken appointments without 24 hours notice. There may be a $35.00 fee imposed for checks returned for any reason.)**

Signature _____ Date _____

Parent or Guardian if patient is under 18