Welcome

Patient Information

Name: _____ **Social Security #:** _____

Last First Initial

Address: _____

_____

City State Zip

Cell Phone: _____ **Home Phone:** _____

Email: _____ **Sex:** ☐ M ☐ F **Age:** _____

Birthdate: _____ **Sex:** ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by: _____ **Occupation:** _____

Business Address: _____ **Business Phone:** _____

Business Email: _____ **Who Referred You:** _____

Notify in case of Emergency: _____ **Home Phone:** _____

Cell Phone: _____ **Business Phone:** _____

Email: _____

Welcome

Primary Insurance

Person Responsible for Account:

Last First Initial

Relation to Patient: **Birthdate:** **Social Security Number:**

Address:

City State Zip

Cell Phone: **Home Phone:**

Email:

Person Responsible Employed by: **Occupation:**

Business Address:

Business Phone: **Business Email:**

Insurance Company: **Phone:**

Insurance Email: **Contact #:**

Group #: **Subscriber #:**

Name of Dependents Under this Plan:

Welcome

Additional Insurance

Subscriber Name:

Last First Initial

Is this Patient Covered by Additional Insurance? ☐ Yes ☐ No

Relation to Patient:

Birthdate:

Social Security Number:

Address (if different from patient):

City State Zip

Cell Phone:

Home Phone:

Email:

Subscriber Employed by:

Business Phone:

Business Address:

Business Email:

Insurance Company:

Phone:

Insurance Email:

Contact #:

Group #:

Subscriber #:

Name of Dependents Under this Plan:

Dental History

What would you like us to do today:

Are you in dental discomfort today:

Former Dentist:

Address:

Dentist's Email:

Phone:

Date of last dentail Care:

Date of last x-rays:

Check if you have had problems with any of the following :

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or Popping Jaw
- ☐ Food collection between teeth
- ☐ Grinding or clenching teeth
- ☐ Loose teeth or broken fillings
- ☐ Peridontal Treatment
- ☐ Sensitivity to Cold
- ☐ Sensitivity to Hot
- ☐ Sensitivity to Sweets
- ☐ Sensitivity When Biting
- ☐ 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: ☐ Yes ☐ No

Other information about your dental health or previous treatment:

Medical History

Physician's Name:

Phone:

Date of last visit:

Have you had any serious illnesses or operations: ☐ Yes ☐ No

If yes, describe:

Are you currently under physician care: ☐ Yes ☐ No

If yes, describe:

Have you ever had a blood transfusion: ☐ Yes ☐ No

If yes, give approximate dates:

Have you ever taken Fen-Phen/Redux: ☐ Yes ☐ No

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel, and Boniva: ☐ Yes ☐ No

Women:

Are you pregnant: ☐ Yes ☐ No

Nursing: ☐ Yes ☐ No

Taking birth control pills: ☐ Yes ☐ No

Check if you have had problems with any of the following :

- ☐ AIDS/HIV Positive
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial heart valves
- ☐ Artificial joints
- ☐ Asthma
- ☐ Atopic (allergy prone)
- ☐ Back problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, persistent
- ☐ Cough up blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Food Allergies
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems

Describe _____

- ☐ Hemophilia / Abnormal Bleeding
- ☐ Herpes
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaw Pain
- ☐ Kidney disease or malfunction
- ☐ Liver Disease
- ☐ Material allergies (latex, wool, metal, chemicals)
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker/Heart Surgery
- ☐ Psychiatric Care
- ☐ Rapid Weight Gain or Loss
- ☐ Radiation Treatment
- ☐ Respitory Disease
- ☐ Rheumatic/Scarlet Fever
- ☐ Shingles
- ☐ Shortness or Breath
- ☐ Skin Rash
- ☐ Spina Bifida
- ☐ Stroke
- ☐ Surgical Implant
- ☐ Swelling of feet or ankles
- ☐ Thyroid Disease or Malfunction
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer/Colitis
- ☐ Venereal Disease

Authorization

I have reviewd 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. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to mem 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 I am financially responsible for all charges whether or not paid by insurance.

Signature: _____ **Date:** _____

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