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 questions we'll be glad to help you. We look forward to working with you and maintaining your dental health.

Patient Information

Name _____ Soc. Sec # _____
Last First MI

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Work Phone _____ Email: _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Patient Employed by _____ Occupation _____

How did you hear about our office? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Primary Insurance

Insured's Name _____ Relation to patient: _____

Birthdate _____ Soc. Sec # _____

Address (if different than patient) _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber # _____

Additional Insurance

Is patient covered by additional dental insurance? Yes No

Insured's Name _____ Relation to patient _____ Birthdate _____

Address _____ Soc Sec# _____

City _____ State _____ Zip _____ Home Phone _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber # _____

The information above is true and correct to the best of my belief. I understand that I am responsible for all of the charges for all services rendered to me or any member of my family. Although I have requested that the dentist bill my insurance company on my behalf, I clearly understand that it is my responsibility to make sure that the bill is paid in a reasonable amount of time. If for any reason, my insurance does not pay any portion of the bill, I further agree to make prompt payment of the bill.

_____ Date _____

Please complete both sides

Dental History

It is important that we know your medical and dental history. These facts have a direct bearing on your Dental Health. The information is strictly confidential and will not be released to anyone without approval. Thank you for completely filling out this questionnaire.

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist_____City, State _____

Y N If we could offer you a simple, effective way of whitening your teeth, would you be interested?
If you could wave a magic want and change one thing about your smile, what would it be?

_____

Y N Are you aware of clenching or grinding your teeth?
Y N Do you have frequent headaches, earaches or neck pain?
Y N Do you notice clicking or popping in your jaws?
Y N Do you experience pain in your jaws?
Y N Are your teeth sensitive to hot, cold, sweets or pressure? (circle)
Y N Have you ever had any periodontal (gum) treatments?
Y N Do your gums bleed, feel tender or irritated?
Y N Have you ever had a serious/difficult problem associated with any previous dental work?
Y N Do you have bad breath or has anyone ever told you that you have bad breath?
Y N Do you snore or do you feel tired after a full nights sleep?

Please rank the following in the order in which they would KEEP YOU FROM having dental treatment.

_____Fear of Pain _____ Lack of Concern _____ Cost of Treatment _____ Missing Work Time

Medical History

Y N Do you have any current health problems? Explain _____

Y N Have you had any serious illnesses or operations? Explain _____

Y N Are you under a Physician's care now? Explain _____
Y N Are you pregnant OR trying to get pregnant?
Y N Do you smoke or use tobacco?

Family Physician _____ Phone # _____

List all medications or vitamin supplements you're currently taking _____

_____

List any allergies: _____

Y N Have you ever been told you need to pre-medicate for your dental visits?
Y N Have you taken the medications Bisphosphorate , Fosamax or Fen-Phen/Redux? (circle)

AIDS/ARC/HIV Positive	Alcoholism	Artificial heart valve	Artificial Joints (hip,knee)
Asthma	Bruise easily	Cancer	Chemotherapy
Cortisone Medicine	Diabetes	Emphysema	Epilepsy or Seizures
Glaucoma	Headaches	Heart Murmur	Heart Problems
Heart Surgery	Hepatitis	High Blood Pressure	Kidney trouble
Liver Disease	Psychiatric Treatment	Radiation Treatment	Lung Disease/COPD

Signature of Patient or Parent/Guardian of child: _____ Date _____

Doctor's Signature _____Date _____