Welcome to our practice.

Patient Information

Date: ______________

Last Name: ______________ First Name: ______________ MI: ____ Mr | Dr | Mrs | Miss | Ms

Mailing Address: (Street, City, State, Zip) ______________

Birthday: __________ Age: _____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Social Security Number: ______________ Drivers License Number: __________ Email: ______________

Occupation: ______________ Employer: ______________

In Case of Emergency Contact (Person not living at same address) Name: ______________ Phone: __________

Account Information

☐ *Person responsible for this account is the same as above*

Last Name: ______________ First Name: ______________ MI: ____ Mr | Dr | Mrs | Miss | Ms

Mailing Address: (Street, City, State, Zip) ______________

Birthday: __________ Age: _____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Social Security Number: ______________ Drivers License Number: __________ Email: ______________

Occupation: ______________ Employer: ______________

Employer Address: (Street, City, State, Zip) ______________

Insurance Information

Primary Insurance Company: ______________ ID Number: __________ Group Number: __________

Mailing Address: (Street, City, State, Zip) ______________

Employer: ______________ Employee Name: ______________ Social Security #: __________

Birthday: ______________ Work Phone: ______________ Cell Phone: ______________

Secondary Insurance Company: ______________ ID Number: __________ Group Number: __________

Mailing Address: (Street, City, State, Zip) ______________

Employer: ______________ Employee Name: ______________ Social Security #: __________

Birthday: ______________ Work Phone: ______________ Cell Phone: ______________

Medical History

Physicians Name, Address and Phone: ______________

Please list any medications, pills, or drugs you are taking: ______________

____

Women: Are you pregnant or trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No

Nursing? ☐ Yes ☐ No

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetic

☐ Other If yes, please explain: ______________

Medical History Cont.

Do you have or have you had? Please check all that apply.

☐ High Blood Pressure	☐ Asthma	☐ Stroke	☐ Hepatitis A B C
☐ Diabetes	☐ Bleeding Problems	☐ Circulatory Problems	☐ Sinus Trouble
☐ Liver Disease	☐ Cancer	☐ Blood Disease	☐ Severe Headaches
☐ Epilepsy or Fainting Spells	☐ AIDS or ARC (HIV Positive)	☐ Artificial Joint	

Indicate any disease, condition, or problem not listed above: ____________________

If yes, please explain: ____________________

Do you have any condition requiring antibiotics prior to dental work? ☐ Yes ☐ No

Check if you have/have had problems with the following:

☐ Bad taste in your mouth	☐ Broken Fillings	☐ Bleeding Gums	☐ Bad odor in your mouth
☐ Periodontal Treatment	☐ Clicking or popping of jaw	☐ Discomfort in head or face	☐ Sensitive to hot, cold
☐ Swelling or bumps	☐ Grinding your teeth	☐ Sensitive to biting	☐ Food collecting between teeth

Are you dissatisfied with your teeth and their appearance? ☐ Yes ☐ No

Do you feel that in the past you have required a lot of dental work? ☐ Yes ☐ No

Do any of your family members wear dentures? ☐ Yes ☐ No

Do you feel that you will eventually lose your teeth and wear dentures? ☐ Yes ☐ No

How long has it been since you've seen a dentist? ____________________

____

We'd love to know how you heard about us.

Family or friend: ____________________ Search Engine: ____________________

Another Doctor: ____________________ Other: ____________________

Please circle any that apply: Radio • Sign (Drive By) • Website • Yellow Pages • Newspaper

Agreement & Consent

I do authorize and give consent to my Dentist and his/her Dental Team to administer treatment, including, but not limited to local anesthesia, analgesia, and other such treatment which may be necessary for the above named patient. I understand that I am responsible for all costs of dental treatment. I authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I authorize the dentist to release all information necessary to secure payment of benefits.

I certify that the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or my patient's) health. I will not hold my Dentist or any members of his/her Dental Team responsible for errors or omissions that I have made in completion of this form. It is my responsibility to notify my Dentist of any changes in the above medical status.

Patient or Responsible Party Signature: x ____________________ Date: __________

Doctor's Signature: x ____________________ Date: __________