



PATIENT INFORMATION

First Name: Last Name: M.I. :

Street Address:

Street Address Line 2:

City: State: Zip Code:

Home Phone: Cell Phone:

Email Address:

SS #: Age: Birth Date:

Marital Status: Sex: Female Male

Employers Name: Occupation:

Business Address:

Business Phone: Business Email:

Who Should We Thank For Referring You?:

EMERGENCY CONTACT: In the event of an emergency, please contact:

First Name: Last Name:

Home Phone: Cell Phone:

PRIMARY INSURANCE INFORMATION

Person Responsible for Account

First Name: Last Name: M.I. :
Relationship to Patient: SS #:
Birth Date: Email Address:
Home Phone: Cell Phone:

(If Different From Patient)

Street Address:
City: State: Zip Code:

(Responsible Persons Information)

Employers Name: Occupation:
Business Address:
Business Phone: Business Email:

(Insurance Information)

Insurance Company Name:
Insurance Phone: Insurance Email:
Contract #: Group #: Subscriber #:
Name of Other Dependants on this Plan:

Check The Box If You Have Had Problems With Any Of The Following

- Bad Breath
- Bleeding Gums
- Sensitivity to Cold
- Loose Teeth or Broken Fillings
- Food Collection Between Teeth
- Sensitivity to Sweets
- Sensitivity When Biting
- Sensitivity to Hot
- Periodontal Treatment
- Grinding or Clenching Teeth
- Clicking or Popping Jaw
- Sores or Growths in Mouth

How Often Do You Brush?

How Often Do You 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

Physicians Name Date of Last Visit

Physicians Phone #

Have Had Any Serious Illnesses or Operations? Yes No

If You Answered Yes to the Above Question, Please Describe

Are You Currently Under a Physicians Care? Yes No

If Yes, Please Explain

Have You Ever Had a Blood Transfusion? Yes No If Yes, Approx Date

Are You Pregnant? Yes No Nursing? Yes No Taking Birth Control Pills? Yes No

Please List Any Current Medications

Please List Any Drug Allergies

Check The Box If You Have Had Problems With Any Of The Following

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Cough Up Blood | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Skin Rash | <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Diseases |
| <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Arthritis / Rheumatism | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Material Allergies |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Surgical Implants | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Asthma | <input type="checkbox"/> Atopic (Allergy Prone) |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Food Allergies |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Herpes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Swollen Feet or Ankles | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Tobacco Habit | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cortisone Treatment | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Ulcer / Colitis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Rapid Weight Loss
or Gain | <input type="checkbox"/> Rheumatic /
Scarlet Fever | | |

If You Answered Yes to Any of the Questions Above, Please Explain

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. 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 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 I am financially responsible for all charges weather or not paid by insurance.

Signature

Date

Payment is due in full at time of treatment, unless prior arrangements have been approved
Please Print and bring with you to your next appointment