

WELCOME TO OUR PRACTICE

In order to help us render the proper dental services to you, please answer ALL the following questions. Thank You.

PATIENT INFORMATION

DATE: _____

Name _____ Birthdate _____ Home Phone: _____
Patient lives with self _____ other _____
Address _____ City _____ State _____ Zip _____
Social Security # _____ - _____ - _____ Sex F M Driver's License # _____
Maiden Name _____ E-mail _____
Check appropriate Minor Single Married Divorced Widowed Separated
Work Phone _____ Cell Phone _____ Pager/Other _____
Employer _____ Occupation _____
Business Address _____ City _____ State _____ Zip _____
Spouse/Parent's Name _____ Employer _____ Work Phone _____
If patient is a student, name of school/college _____ City _____ State _____
Person to contact in case of emergency _____ Phone _____
Relationship to patient _____ Who may we thank for referring you? _____

RESPONSIBLE PARTY

Name of Person Responsible for this account _____
Relationship to Patient _____ Is this person currently a patient in our office? Yes No
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Driver's License # _____
Social Security # _____ - _____ - _____ Birthdate _____ Occupation _____
Employer _____
Address of Employer _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____
Address _____ City _____ State _____ Zip _____
Work Phone _____ Social Security # _____ - _____ - _____ Date Employed _____
Employer _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group/Plan # _____
Insurance Company Address _____ City _____ State _____ Zip _____
Have you used any of your insurance benefits at another dental office? _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? YES NO If yes, complete the following

Name of Insured _____ Relationship to Patient _____
Address _____ City _____ State _____ Zip _____
Work Phone _____ Social Security # _____ - _____ - _____ Date Employed _____
Employer _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group/Plan # _____
Insurance Company Address _____ City _____ State _____ Zip _____

We file insurance as a courtesy to our patients. We require a copy of your insurance card, any fee schedules provided by your employer and a completed signed claim form. We must have the complete and correct insurance information in order to verify your benefits and file your claims. If we encounter problems verifying or collecting your benefits, we may require payment from you and allow you to request reimbursement directly from your insurance carrier. Please contact us with any new insurance information at least 24 hours prior to your appointments.

PLEASE COMPLETE THE MEDICAL HISTORY ON THE NEXT PAGE

Date _____
Patient Name _____ Birthdate _____
Address _____ City _____ State _____ Zip _____

PATENT MEDICAL HISTORY

General Health: Excellent _____ Good _____ Fair _____ Poor _____

Name of Physician _____ Office Phone _____

Are you taking any medications now? Yes _____ No _____ If yes, why? _____

Name of Medications and dosage (prescription and non prescription) _____

Vitamins or herbal medicines _____

For women only Are you pregnant? Yes _____ No _____
Are you nursing? Yes _____ No _____
Are you taking birth control pills? Yes _____ No _____

Note: Antibiotics may make birth control pills ineffective.

Are you allergic to any of the following?

Allergic to Penicillin Yes _____ No _____
Allergic to Codeine Yes _____ No _____
Allergic to Erythromycin Yes _____ No _____
Allergic to Latex Yes _____ No _____

Any other allergies _____

Any unusual reactions to local anesthetics? Yes _____ No _____

Have you ever taken Fen-Phen or Redux? Yes _____ No _____

Have you ever been treated for any of the following?

Heart Murmur	Yes _____ No _____	Asthma	Yes _____ No _____
Rheumatic Fever	Yes _____ No _____	Epilepsy	Yes _____ No _____
Mitral Valve Prolapse	Yes _____ No _____	Hepatitis	Yes _____ No _____
Hip, Knee or Joint Replacement	Yes _____ No _____	Prolonged Bleeding	Yes _____ No _____
Heart Disease	Yes _____ No _____	Blood Disorders	Yes _____ No _____
Abnormal Blood Pressure	Yes _____ No _____	HIV Positive/AIDS/STDS	Yes _____ No _____
Tuberculosis/Lung Disease	Yes _____ No _____	Ulcers	Yes _____ No _____
Diabetes	Yes _____ No _____	Sinus Problems	Yes _____ No _____
Stroke	Yes _____ No _____	Glaucoma	Yes _____ No _____
Heart Valve Replacement	Yes _____ No _____	Dry mouth or eyes	Yes _____ No _____
Radiation Treatment	Yes _____ No _____	Psychiatric Care	Yes _____ No _____
Cancer	Yes _____ No _____	Chemical Dependency	Yes _____ No _____
Chemotherapy	Yes _____ No _____	Any other contagious disease?	Yes _____ No _____

If yes, when? _____ Please name _____

Please explain any yes answers _____

Do you smoke? Yes _____ No _____ Use smokeless tobacco? Yes _____ No _____

Would you change anything about the appearance of your teeth? Yes _____ No _____ If yes, what would you change? _____

I certify that I have read and understand the above information and that to the best of my knowledge the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X _____
PATIENT, PARENT OR GUARDIAN RELATIONSHIP TO MINOR DATE