



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 in maintaining your dental health.

Patient Information

Patient Name: Last First MI Date:
Male Female Married Single Other:
Social Security #: Birth Date: Age: Driver's License#: State:
Phone Home: Work: Cell:
Email:
Home Address:
Street: City: State: Zip:
Patient Employed by: Occupation:
Business Address: Business Phone:
Whom may we thank for referring you?
In case of an emergency, who should be notified?

Spouse Information

The following is for The Patient's Spouse
Name:
Male Female Married Single Other:
Social Security #: Birth Date:
Phone Home: Work: Cell:
Home Address:
Street: City: State: Zip:
Employer Name: Occupation:
Business Address:

Dental Insurance

Is the patient covered by Dental Insurance Yes No Name of Insurance Company:
Subscriber Name: Relation to Patient: Birth Date:
Group #: Subscriber I.D. #:
Address (If different from patient's): Phone:
City: State: Zip:
Subscriber Employed by: Business Phone:
Social Security #: Insurance Company Address:
City: State: Zip:

Dental History

Date of last dental care:
Reason for today's visit:
Former Dentist:
Check ( ) if you have had problems with any of the following:
Bad Breath Grinding Teeth Sensitivity to hot
Bleeding Gums Loose teeth or broken fillings Sensitivity to sweets
Clicking or popping jaw Periodontal treatment Sensitivity when biting
Food collection between teeth Sensitivity to cold Sores or growths in your mouth
How often do you floss? How often do you brush?
Would you or someone you know be interested in straighter teeth, whiter teeth, or reducing snoring? Explain:

Parent or Guardian Information - Person Responsible for the Account

The following is for:  Parent  Guardian

Name: \_\_\_\_\_

Male  Female  Married  Single  Other: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Driver's License#: \_\_\_\_\_ State: \_\_\_\_\_

Phone Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Home Address: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_

Second Parent or Guardian Information The following is for:  Parent  Guardian

Name: \_\_\_\_\_

Male  Female  Married  Single  Other: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Driver's License#: \_\_\_\_\_ State: \_\_\_\_\_

Phone Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Home Address: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Have you had any serious illnesses or operations?  Yes  No If yes, describe: \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No If yes, give approximate dates: \_\_\_\_\_

(Women) Are you pregnant?  Yes  No Nursing?  Yes  No Taking birth control pills?  Yes  No

Check (✓) if you have or have had any of the following:

- AIDS
- Anemia
- Arthritis, Rheumatism
- Artificial Heart Valves
- Artificial Joints
- Asthma
- Back Problems
- Blood Disease
- Cancer
- Chemical Dependency
- Chemotherapy
- Circulatory Problems
- Cortisone Treatments
- Cough, Persistent
- Cough up Blood
- Diabetes
- Epilepsy
- Fainting
- Glaucoma
- Headaches
- Heart Murmur
- Heart Problems
- Describe: \_\_\_\_\_
- Hemophilia
- Hepatitis
- High Blood Pressure
- HIV Positive
- Jaw Pain
- Kidney Disease
- Liver Disease
- Mitral Valve Prolapse
- Nervous Problems
- Pacemaker
- Psychiatric Care
- Radiation Treatment
- Respiratory Disease
- Rheumatic Fever
- Scarlet Fever
- Shortness of Breath
- Skin Rash
- Stroke
- Swelling of Feet or Ankles
- Thyroid Problems
- Tobacco Habit
- Tonsillitis
- Tuberculosis
- Ulcer
- Venereal Disease

MEDICATIONS - List medications you are currently taking: \_\_\_\_\_

ALLERGIES - Codeine Allergy  Yes  No Penicillin Allergy  Yes  No Anesthetic Allergy  Yes  No

Latex Allergy  Yes  No Other Allergies: \_\_\_\_\_

Please Initial

- \_\_\_\_\_ I acknowledge that I have received a copy of the HIPPA Policy.
- \_\_\_\_\_ I authorize my insurance company to pay to the dentist or dental group 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 whether or not paid by insurance.
- \_\_\_\_\_ I have received a copy of the financial policy.
- \_\_\_\_\_ Payment is due in full unless prior arrangements have been approved.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_