Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient # ______________________

SS # ______________________

Date ______________________

PATIENT INFORMATION

Name ______________________ Birthdate ______________ Phone (_____) ______________

Address ______________________ City ______________ State __________ Zip __________

Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

E-mail ______________________ Alt. Phone #1 (_____) ______________ Alt. Phone #2 (_____) ______________

Employer/School ______________________ Employer/School Phone (_____) ______________

Employer/School Address ______________________ City ______________ State __________ Zip __________

Spouse or Parent's Name ______________________ Employer ______________ Work Phone (_____) ______________

Whom may we thank for referring you? ______________________

Person to contact in case of emergency ______________________ Phone (_____) ______________

RESPONSIBLE PARTY

Name of Person
Responsible for this Account ______________________ Relation to Patient ______________

Address ______________________ Home Phone (_____) ______________

Driver's License # ______________________ Birthdate ______________ Bank ______________

Employer ______________________ Work Phone (_____) ______________

Currently a patient in our office? ☐ Yes ☐ No E-mail ______________ Cell Phone (_____) ______________

INSURANCE INFORMATION

Name of Insured ______________________ Relation to Patient ______________

Birthdate ______________ Social Security # ______________ Date Employed ______________

Employer ______________________ Work Phone (_____) ______________

Employer Address ______________________ City ______________ State __________ Zip __________

Insurance Company ______________________ Group # ______________ Union or Local # ______________

Address ______________________ City ______________ State __________ Zip __________

How much is your deductible? __________ How much have you used? __________ Max. Annual Benefit __________

ADDITIONAL INSURANCE

Name of Insured ______________________ Relation to Patient ______________

Birthdate ______________ Social Security # ______________ Date Employed ______________

Employer ______________________ Work Phone (_____) ______________

Employer Address ______________________ City ______________ State __________ Zip __________

Insurance Company ______________________ Group # ______________ Union or Local # ______________

Address ______________________ City ______________ State __________ Zip __________

How much is your deductible? __________ How much have you used? __________ Max. Annual Benefit __________

– O V E R –

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DENTAL HISTORY

Reason for today's visit ______________________ Date of last dental care ______________________

Former Dentist ______________________ Date of last dental X-rays ______________________

Address ____

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

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between the teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? ______________________ How often do you brush? ______________________

MEDICAL HISTORY

Physician's Name ______________________ Date of last visit ______________________

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

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

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Anemia	☐	☐	Congenital Heart Lesions	☐	☐	Hepatitis	☐	☐	Scarlet Fever
☐	☐	Arthritis, Rheumatism	☐	☐	Cortisone Treatments	☐	☐	Hernia Repair	☐	☐	Shortness of Breath
☐	☐	Artificial Heart Valves	☐	☐	Cough, Persistent	☐	☐	High Blood Pressure	☐	☐	Skin Rash
☐	☐	Artificial Joints, Pins, etc.	☐	☐	Cough up Blood	☐	☐	HIV/AIDS	☐	☐	Stroke
☐	☐	Asthma	☐	☐	Diabetes	☐	☐	Jaw Pain	☐	☐	Swelling of Feet or Ankles
☐	☐	Back Problems	☐	☐	Epilepsy	☐	☐	Kidney Disease	☐	☐	Thyroid Problems
☐	☐	Bleeding Abnormally	☐	☐	Fainting	☐	☐	Liver Disease	☐	☐	Tobacco Habit
☐	☐	Blood Disease	☐	☐	Glaucoma	☐	☐	Mitral Valve Prolapse	☐	☐	Tonsillitis
☐	☐	Cancer	☐	☐	Headaches	☐	☐	Pacemaker	☐	☐	Tuberculosis
☐	☐	Chemical Dependency	☐	☐	Heart Murmur	☐	☐	Radiation Treatment	☐	☐	Ulcer
☐	☐	Chemotherapy	☐	☐	Heart Problems	☐	☐	Respiratory Disease	☐	☐	Venereal Disease
☐	☐	Circulatory Problems	☐	☐	Hemophilia	☐	☐	Rheumatic Fever			

List medications you are currently taking and the correlating diagnosis: ______________________

Allergies: ______________________

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with ______________________ and assign directly to
Name of Insurance Company(ies)

Dr.______________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

______________________ Signature of Patient, Parent, Guardian or Personal Representative ______________________ Date

______________________ Please print name of Patient, Parent, Guardian or Personal Representative ______________________ Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.