Date _____ Date of Birth _____

Patient's Name _____ ☐Male ☐Female
Last First Initial

If Patient is child, parent's name _____
Last First Initial

How do you wish to be addressed? _____

Residence Address _____

City _____ State _____ Zip _____

Home Phone (___) _____ Work Phone (___) _____ Mobile Phone (___) _____

Patient employed by _____ Current position _____

Drivers License Number _____

Patient's Social Security Number _____ If minor, parent's SSN _____

Someone to notify in case of emergency _____ Phone Number (___) _____

Dental Insurance First Coverage

Employee Name _____ Date of Birth _____

Employee Social Security Number _____

Employer _____

Name of Insurance Company _____

Insurance Company Telephone Number (___) _____

Program or Policy Number _____ Group Number _____

Dental Insurance Second Coverage

Employee Name _____ Date of Birth _____

Employee Social Security Number _____

Employer _____

Name of Insurance Company _____

Insurance Company Telephone Number (___) _____

Program or Policy Number _____ Group Number _____

RELEASE

The dental care necessary to treat my existing conditions has been explained to me and my questions have been answered satisfactorily. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of my information concerning my, or my child's, health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize release of any information concerning my, or my child's health care, advice, and treatment to another dentist. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier may pay less than the actual bill of services and that I am financially responsible for payments in full on all accounts. By signing this statement I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid in whole or part by my dental care payor. I attest to the accuracy of the information on this page.

Patient/Guardian Signature _____ Date _____

Patient's Name _____ Date of Birth _____

1. Physician's Name _____ Phone Number (___) _____

2. If you are currently under a physician's care, list reason(s) _____

3. Are you taking any medications/substances/supplements? (if yes, inform doctor/hygienist)	☐yes ☐no
4. Are you allergic to any medications /substances?	☐yes ☐no
5. Do you have problems with penicillin, antibiotics, anesthetics or other medications?	☐yes ☐no
6. Are you sensitive to any metals or latex?	☐yes ☐no
7. Are you pregnant or suspect you may be?	☐yes ☐no
8. Have you ever been treated for or told you have heart disease?	☐yes ☐no
9. Do you have a pacemaker or an artificial heart valve implant?	☐yes ☐no
10. Have you ever had rheumatic fever?	☐yes ☐no
11. Are you aware of any heart murmurs?	☐yes ☐no
12. Do you have high or low blood pressure?	☐yes ☐no
13. Have you ever had a serious illness or major surgery? _____	☐yes ☐no
14. Have you ever had radiation treatment or chemo therapy?	☐yes ☐no
15. Do you have inflammatory disease, such as arthritis or rheumatism?	☐yes ☐no
16. Do you have any artificial joints/prosthesis?	☐yes ☐no
17. Do you have any blood disorders, such as anemia, leukemia, etc?	☐yes ☐no
18. Have you ever bled excessively after being cut or injured?	☐yes ☐no
19. Do you have any stomach, kidney, or liver problems? _____	☐yes ☐no
20. Are you diabetic?	☐yes ☐no
21. Do you have asthma?	☐yes ☐no
22. Do you have epilepsy or seizure disorders?	☐yes ☐no
23. Do you or have you had a sexually transmitted disease?	☐yes ☐no
24. Have you tested HIV positive?	☐ yes ☐no
25. Have you had or do you test positive for hepatitis?	☐yes ☐no
26. Do you have or have you had TB?	☐yes ☐no
27. Do you smoke, chew, or use any other forms of tobacco?	☐yes ☐no
28. Do you consume alcoholic beverages?	☐yes ☐no
29. Do you habitually use controlled substances?	☐yes ☐no
30. Have you had psychiatric treatment?	☐yes ☐no

31. Do you have any disease, condition, or problem not listed? Explain _____

_____

32. Is there anything else we should know about your health that we have not covered on this form? Explain

_____

I certify that the above information is complete and accurate.

Patient's/Guardian's Signature _____ Date _____

Dentist Signature_____ Date _____