# Welcome

## ABOUT YOU

Today's Date: ____/____/____

Patient Name: _____
LAST FIRST MI

What you prefer to be called: _____ ❑ Male ❑ Female

Birthdate: ____/____/____ SS#: _____

Mailing Address: _____
CITY STATE ZIP

Home Phone #: ( ____ ) _____

Cell Phone #: ( ____ ) _____

E-mail Address: _____

Referred by: _____

Employer: _____

Occupation: _____

Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Spouse's Name: _____

## INSURANCE INFO

### Primary Dental Insurance

Company Name: _____

Insured's ID#: _____

Group # (Plan or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

### Secondary Dental Insurance

Company Name: _____

Insured's ID#: _____

Group # (Plan or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

## ACCOUNT INFO

### Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____
City State ZIP

SS# : _____

## IN EVENT OF EMERGENCY

Whom should we contact? _____

Relation: _____

Home Phone #: ( ____ ) _____

Cell Phone #: ( ____ ) _____

Who is your Medical Doctor: _____

Medical Doctor's Phone #: ( ____ ) _____

PLEASE CONTINUE ON BACK

# DENTAL INFORMATION

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation Are you in pain? ❑ No ❑ Yes How Long? _____

Please indicate ☑ any of the following problems:

❑ Discomfort, clocking or popping in jaw
❑ Blisters/Sores in or around the mouth
❑ Broken/Chipped tooth
❑ Lost/Broken Filling(s)
❑ Locking Jaw
❑ Teeth grinding
❑ Stained teeth
❑ Sensitive tooth, teeth or gums
❑ Bad breath
❑ Red, swollen or bleeding gums
❑ Ringing in Ears
❑ Other: _____

Do you require pre-medication? ❑ Yes ❑ No

Previous Dentist: _____ Phone#: (_____) _____

Last Dental exam: ____/____/____ Last Dental X-rays: ____/____/____

Times a day you brush?_____ Times a week you floss?_____ What type of tooth brush bristles do you use? ❑ Soft ❑ Medium ❑ Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

# MEDICAL HISTORY

**What medications are you taking? ❑ Nerve pills ❑ Pain Killers (including aspirin) ❑ Muscle relaxers ❑ Stimulants**
**❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Meds for Osteoporosis**
**❑ Other(s), please list:** _____

**Do you have or have you had any of the following diseases, medical conditions or procedures? Circle Y or N**

Y N Heart Attack / Stroke
Y N Heart Surg./Pacemaker
Y N Heart Murmur
Y N Rheumatic Fever
Y N Mitral Valve Prolapse
Y N Artificial Valves
Y N Heart Disease
Y N Congenital Heart Defect
Y N Chest Pains
Y N Scarlet Fever
Y N Nervousness

Y N Throid Problems
Y N Kidney Problems
Y N Liver Problems
Y N Respiratory Problems
Y N Sinus Problems
Y N Stomach Problems
Y N Psychiatric Problems
Y N Venereal Disease
Y N Alcohol/Drug Abuse
Y N Tuberculosis TB
Y N Jaw Problems TMJ/TMD

Y N Cancer/Tumors
Y N Shingles
Y N Hepatitis
Y N HIV +/AIDS/ARC
Y N Arthritis / Rheumatism
Y N Artificial Bones/Joints
Y N Emphysema
Y N Fainting/Seizures/Epilepsy
Y N Severe/Frequent Headaches
Y N Frequent Neck Pain
Y N Back Problems

Y N Cosmetic Surgery
Y N Xray or Cobalt Treatment
Y N Chemotherapy
Y N Asthma
Y N Difficulty Breathing
Y N Diabetes/Hypoglycemia
Y N Leukemia
Y N Anemia
Y N High/Low Blood Pressure
Y N Bleeding Problems
Y N Glaucoma

Please list any other surgeries or medical conditions you have or ever had: _____

_____

Are you allergic to any of the following? ❑ Latex ❑ Penicillin / Amoxicillin ❑ Tetracycline ❑ Aspirin ❑ Dental Anesthetics

❑ Foods: _____ ❑ Others: _____

Do you use tobacco? ❑ No ❑ Yes

Please rate your general health from 1 - 10: _____ Do you wear contact lenses? ❑ Yes ❑ No

**For Women:** Are you taking Birth Control Pills? ❑ Yes ❑ No

Are you Pregnant ? ❑ No ❑ Yes / How Long _____ Are you nursing? ❑ Yes ❑ No

Do you have children? ❑ Yes ❑ No How Many ? _____

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____ Date ____/____/____

❑ Adult Patient ❑ Patient or Guardian ❑ Spouse