Welcome to our office!

We appreciate the confidence you place with us to provide quality dental services.

Patient Name _____Prefer to be called _____

Date of Birth _____ Sex _____ Single( ) Separated ( ) Married ( ) Divorced ( ) Widowed ( )

Home Address _____ City _____State _____ Zip _____

Billing Address (if different) _____ City _____ State _____ Zip _____

Home phone _____Cell _____Work _____ Email _____

Social Security # _____-_____-_____ Employer_____

Spouse's Name _____ Spouse's Employer _____

Emergency Contact _____ Phone _____

Person responsible for account _____

Whom may we thank for referring you to our office? _____

PRIMARY DENTAL INSURANCE

Subscriber's Name _____ Date of Birth _____

Social Security # _____-_____-_____ Relationship to Subscriber _____

If student, name of school _____

Name of Insurance Company _____ Phone _____

Group # _____ ID #_____ Employer _____

SECONDARY DENTAL INSURANCE

Subscriber's Name _____ Date of Birth _____

Social Security # _____-_____-_____ Relationship to Subscriber _____

Name of Insurance Company _____ Phone _____

Group # _____ ID #_____ Employer _____

HEALTH HISTORY

Name: _____

Are you in good health? ( ) YES ( ) NO If no, please explain _____
Are you under a physician's care at this time? ( ) YES ( ) NO If yes, please explain _____
Physician's Name _____ Phone _____
Have you been hospitalized in the past two years? ( ) YES ( ) NO If yes, please explain _____
Do you smoke? ( )YES ( )NO If yes, how many packs a day? _____

Do you have or have you ever had any of the following:

- Allergies / Hives
- Anemia
- Artificial Joint or valve
- Arthritis
- Heart Disease
- Angina
- Heart Murmur / Mitral Valve Prolapse / Heart defect
- Pacemaker
- Fainting Spells
- Blood Transfusion / Blood Disorder
- Cancer / Tumor
- Chemo / Radiation Therapy
- Hepatitis A, B, C
- Diabetes
- Epilepsy / Seizures / Fainting Spells
- Psychological Problems
- Drug Abuse
- Alcoholism
- Kidney Disease
- Excessive Bleeding
- High Blood Pressure
- Low Blood Pressure
- Stroke
- Venereal Disease
- Tuberculosis
- HIV Positive / AIDS
- Sinus Problems

Are you allergic to, or have you reacted adversely to any of the following?

- Latex
- Penicillin
- Local anesthetics ("Novacaine")
- Codeine or other narcotics
- Sulfa Drugs
- Barbiturates, sedatives, or sleeping pills
- Aspirin
- Other _____

Are you taking any of the following?

- Aspirin
- Blood Thinners
- Antibiotics
- Anti-depressants
- Insulin
- Cortisone or other steroids
- Osteoporosis (bone density) medicine

Please list medications you are currently taking:_____

WOMEN: Are you pregnant? ( )YES ( )NO If yes, due date? _____ Are you taking birth control pills? ( )YES ( )NO

DENTAL HISTORY

Previous Dentist _____Phone _____
Date of you last dental exam _____Last Xrays _____ Last dental treatment_____

Do you grind or clench your teeth? ( ) YES ( ) NO
Do you have discomfort in your jaw? ( ) YES ( ) NO
Do your gums bleed easily? ( ) YES ( ) NO
Do your gums bleed when you floss? ( )YES ( ) NO
Do you gag easily? ( ) YES ( ) NO

I authorize the release of any information necessary to process my insurance claim. I hereby authorize payment to the dentist of the insurance benefits otherwise payable to me. A copy of this signature is as valid as the original. The above information is true and I will notify you of any changes. I also understand that failure to show for an appointment will be charged to my account, payable by me and could result in the termination of patient / dentist relations.

Signature _____ Date _____