

Date:

PATIENT INFORMATION

Name _____ Birthdate ___/___/___ Social Security # ____-____-____
Address _____ City _____ State ____ Zip _____
Home Phone (____) ____-____ Cell Phone (____) ____-____ Email _____
Check Appropriate: Minor Single Married Divorced Widowed Separated
Patient's or Parent's Employer: _____ Work Phone (____) ____-____
Business Address _____ City _____ State ____ Zip _____
Spouse or Parent's Name _____ Employer _____ Work Phone (____) ____-____
If Patient is a Student, Name of School attended _____ City _____ State _____
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 _____
Driver's Lic # _____ Birthdate ___/___/___ Social Security # ____-____-____
Address _____ City _____ State ____ Zip _____
Currently a Patient in our office? Yes No Home Phone (____) ____-____
Employer _____ Work 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 _____

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 _____

MEDICAL HISTORY

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 Due date: _____ Nursing? Yes No Taking birth control pills? Yes No

	Yes	No		Yes	No		Yes	No		Yes	No
Allergies, hay fever sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Circulatory problems	<input type="checkbox"/>	<input type="checkbox"/>	Any Immune Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	Skin rash	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis, Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone treatments	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Slow healing wounds	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valves	<input type="checkbox"/>	<input type="checkbox"/>	Cough, persistent or bloody	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of feet or ankles	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Required Hospitalization?	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Have you used steroids?	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Date of last episode _____			Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatment	<input type="checkbox"/>	<input type="checkbox"/>	Tumor or growth on head or neck	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding abnormally with	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
extractions or surgery			Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease, clotting disorders	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	Weight loss, unexplained	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
Chemical dependency	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>			

List medications you are currently taking:

Allergy to Penicillin, Aspirin or Other Drugs: Yes No Specify: _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental visit _____

Former dentist _____ Date of last dental x-rays _____

	Yes	No		Yes	No		Yes	No
Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	Clench or grind teeth	<input type="checkbox"/>	<input type="checkbox"/>	Orthodontic treatment	<input type="checkbox"/>	<input type="checkbox"/>
Blisters on lips or mouth	<input type="checkbox"/>	<input type="checkbox"/>	Growths or sore spots in your mouth	<input type="checkbox"/>	<input type="checkbox"/>	Nitrous Oxide (laughing gas)	<input type="checkbox"/>	<input type="checkbox"/>
Burning sensation on tongue	<input type="checkbox"/>	<input type="checkbox"/>	Gums swollen, tender or bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Periodontal treatment	<input type="checkbox"/>	<input type="checkbox"/>
Chew on one side of mouth	<input type="checkbox"/>	<input type="checkbox"/>	Jaw pain or tiredness	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to pressure or irritants (cold, heat or sweets)	<input type="checkbox"/>	<input type="checkbox"/>
Cigarette, pipe or cigar smoking	<input type="checkbox"/>	<input type="checkbox"/>	Lip or cheek biting	<input type="checkbox"/>	<input type="checkbox"/>			
Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	Loose teeth or broken fillings	<input type="checkbox"/>	<input type="checkbox"/>			
Food collection between the teeth	<input type="checkbox"/>	<input type="checkbox"/>	Mouth breathing	<input type="checkbox"/>	<input type="checkbox"/>			

How often do you floss? _____ How often do you brush? _____

Have you ever had an allergic reaction or allergic symptoms to Novocaine, local or general anesthetics? Yes No

Have you had trouble from previous dental care? Yes No _____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor 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 my insurance. I authorize the use of this signature on all insurance submissions.

Signature of patient or parent if minor

Date

Signature of doctor

Date