

# WELCOME

## 1

### ABOUT YOU

Today's Date: \_\_\_\_\_ File #: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
LAST FIRST MI

What You Prefer To Be Called: \_\_\_\_\_ ☐ Male ☐ Female

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ SS #: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

CITY STATE ZIP

Home Phone #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Ext: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Referred By \_\_\_\_\_

Employer: \_\_\_\_\_ How Long? \_\_\_\_\_

Employer's Address: \_\_\_\_\_

CITY STATE ZIP

Occupation: \_\_\_\_\_

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced

☐ Separated ☐ Widowed

Spouse's Name \_\_\_\_\_

Do you have children? ☐ Yes ☐ No How many? \_\_\_\_\_

## 2

### INSURANCE INFO

#### Primary Dental Insurance

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

CITY STATE ZIP

Phone #: \_\_\_\_\_

Insured's ID #: \_\_\_\_\_

Group # (Plan, Local or Policy#): \_\_\_\_\_

Insured's Name \_\_\_\_\_

Relation \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

#### Secondary Dental Insurance

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

CITY STATE ZIP

Phone #: \_\_\_\_\_

Insured's ID #: \_\_\_\_\_

Group # (Plan, Local or Policy#): \_\_\_\_\_

Insured's Name \_\_\_\_\_

Relation \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

## 3

### ACCOUNT INFO

Person ultimately responsible for account

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Billing Address: \_\_\_\_\_

CITY STATE ZIP

SS #: \_\_\_\_\_

Drivers License #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_

Payment method: ☐ Cash ☐ Check

☐ Credit Card - Enter card # above (if accepted)

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

## 4

### IN EVENT OF EMERGENCY

Whom should we contact? \_\_\_\_\_

Relation: \_\_\_\_\_

Home Phone #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

Who is your Medical Doctor? \_\_\_\_\_

Medical Doctor's Phone #: \_\_\_\_\_

**PLEASE CONTINUE ON BACK**



5

## 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, clicking or popping in jaw. ☐ Lost / Broken Fillings(s) ☐ Stained Teeth

☐ Red, swollen or bleeding gums. ☐ Teeth Grinding ☐ Locking Jaw

☐ Sensitive tooth, teeth or gums. ☐ Ringing in Ears ☐ Bad breath

☐ Blisters / Sores in or around mouth ☐ Broken / Chipped tooth

☐ Other: \_\_\_\_\_

Do you require pre-medication? ☐ Yes ☐ No ☐ Don't know

Previous Dentist

Name \_\_\_\_\_ 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 you smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

6

## 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?**

<input type="checkbox"/> Heart Attack / Stroke	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Cancers / Tumors	<input type="checkbox"/> Cosmetic Surgery
<input type="checkbox"/> Heart Surg. / Pacemaker	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Shingles	<input type="checkbox"/> Xray or Cobalt Treatment
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Hemotherapy
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> HIV+ / AIDS / ARC	<input type="checkbox"/> Asthma
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Arthritis / Rheumatism	<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Artificial Valves	<input type="checkbox"/> Stomach Problems / Ulcers	<input type="checkbox"/> Artificial Bones / Joints	<input type="checkbox"/> Diabetes / Hypoglycemia
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Psychiatric Problems	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Leukemia
<input type="checkbox"/> Congenital Heart Defect	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Fainting / Seizures / Epilepsy	<input type="checkbox"/> Anemia
<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Alcohol / Drug Abuse	<input type="checkbox"/> Severe / Frequent Headaches	<input type="checkbox"/> High / Low Blood Pressure
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Tuberculosis TB	<input type="checkbox"/> Frequent Neck Pain	<input type="checkbox"/> Bleeding Problems
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Jaw Problems TMJ / TMD	<input type="checkbox"/> Back Problems	<input type="checkbox"/> 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 / How used? \_\_\_\_\_ How much \_\_\_\_\_ How long? \_\_\_\_\_

Please rate your general health from 1-10: \_\_\_\_\_ Do you wear contact lenses ☐ Yes ☐ No

Have you ever taken the drug Phen-fen and or Redux? ☐ Yes ☐ No

**For women:** Are you taking birth control pills ☐ Yes ☐ No How many children have you had? \_\_\_\_\_

Are you pregnant? ☐ No ☐ Yes / How long? \_\_\_\_\_ Are you nursing? ☐ Yes ☐ No

- 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 any changes to the information I have provided.

Signature \_\_\_\_\_ Date \_\_\_\_\_

☐ Adult Patient

☐ Parent or Guardian

☐ Spouse

UPDATE  
OFFICE USE

Initials \_\_\_\_\_ Date \_\_\_\_\_

Comments \_\_\_\_\_

Initials \_\_\_\_\_ Date \_\_\_\_\_

Comments \_\_\_\_\_

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How Long? \_\_\_\_\_

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Do you require pre-medication?

☐ Yes☐ No☐ Don't know

Previous Dentist

Name \_\_\_\_\_

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

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Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke

Y N Thyroid Problems

Y N Cancers / Tumors

Y N Cosmetic Surgery

Y N Heart Surg. / Pacemaker

Y N Kidney Problems

Y N Shingles

Y N Xray or Cobalt Treatment

Y N Heart Murmur

Y N Liver Problems

Y N Hepatitis

Y N Hemotherapy

Y N Rheumatic Fever

Y N Respiratory Problems

Y N HIV+ / AIDS / ARC

Y N Asthma

Y N Mitral Valve Prolapse

Y N Sinus Problems

Y N Arthritis / Rheumatism

Y N Difficulty Breathing

Y N Artificial Valves

Y N Stomach Problems / Ulcers

Y N Artificial Bones / Joints

Y N Diabetes / Hypoglycemia

Y N Heart Disease

Y N Psychiatric Problems

Y N Emphysema

Y N Leukemia

Y N Cogential Heart Defect

Y N Venereal Disease

Y N Fainting / Seizures / Epilepsy

Y N Anemia

Y N Chest Pains

Y N Alcohol / Drug Abuse

Y N Severe / Frequent Headaches

Y N High / Low Blood Pressure

Y N Scarlet Fever

Y N Tuberculosis TB

Y N Frequent Neck Pain

Y N Bleeding Problems

Y N Nervousness

Y N Jaw Problems TMJ / TMD

Y N Back Problems

Y N Glaucoma

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Do you use tobacco?

☐ No☐ Yes / How used? \_\_\_\_\_

How much \_\_\_\_\_

How long? \_\_\_\_\_

Please rate your general health from 1-10: \_\_\_\_\_

Do you wear contact lenses

☐ Yes☐ No

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☐ Yes☐ No

For women: Are you taking birth control pills

☐ Yes☐ No How many children have you had?

Are you pregnant?

☐ No☐ Yes / How long? \_\_\_\_\_Are you nursing? ☐ Yes☐ No

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Signature \_\_\_\_\_

Date \_\_\_\_\_

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Date \_\_\_\_\_

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Date \_\_\_\_\_

Comments \_\_\_\_\_