

Welcome

INSURANCE INFORMATION

Name of Insured: _____

Birthday: _____ SSN: _____

Relation: _____

Insurance Company: _____

Address: _____

City State Zip

Group #: _____

Phone #: _____

Insured Employer: _____

ABOUT YOU

Today Date: _____

Please Circle one: Dr. Mr. Mrs. Ms. Miss

Patient Name: _____
Last First MI

Preferred Name: _____ M F

Birthday: _____ SSN: _____

Married Single Divorced Widowed Minor

Address: _____

City State Zip

Drivers License # _____ Exp _____

Home Phone: _____

Cell Phone: _____

Email: _____

Work Phone: _____

Employer: _____

How do you prefer us to contact you? _____

**Whom may we thank for referring you to our practice?
or How did you hear about us?**

EMERGENCY CONTACT

Whom should we contact? _____

Relation: _____

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

Who is your Medical Doctor? _____

Medical Doctor's Phone# _____

RESPONSIBLE PARTY

Name: _____

Relation: _____

Billing Address (If different): _____

City State Zip

SSN: _____ Birth Date: _____

Work #: _____ Ext: _____

Cell #: _____ Drivers Lic. # _____

PLEASE CONTINUE ON BACK

PATIENT INFORMATION

DENTAL INFORMATION

Are you in pain? Y N How Long? _____

Are your teeth sensitive to? Hot Cold Sweets Pressure

Do your gums hurt or bleed? Y N When? _____

How often do you brush and floss your teeth? _____

Have you ever had any Orthodontic treatment? Y N When? _____

Reason for Today's visit? _____

MEDICAL INFORMATION

Do you have any of the following diseases, medical conditions or procedures? Please check all that applies.

- Heart Attack/Stroke
- Heart Surgery
- Liver Problems
- Respiratory Problems
- Mitral Valve Prolapse
- Artificial Valve
- Heart Disease
- Congenital Heart Defect
- Epilepsy
- Severe/Frequent Headache
- Frequent Neck Pain
- Back Problems

- Thyroid problems
- Pacemaker
- Hepatitis
- HIV
- Sinus Problems
- Stomach Problems/Ulcers
- Psychiatric Problem
- Venereal Disease
- Anemia
- High/Low Blood Pressure
- Bleeding Problems
- Glaucoma

- Cancer/tumors
- Kidney Problems
- Chemotherapy
- AIDS/ARC
- Arthritis/Rheumatism
- Artificial Bones/Joints
- Emphysema
- Fainting
- Chest Pains
- Scarlet Fever
- Nervousness
- Pregnancy

- Cosmetic Surgery
- Heart Murmur
- Rheumatic Fever
- Asthma
- Difficulty Breathing
- Diabetes/Hypoglycemia
- Leukemia
- Seizure
- Alcohol/Drug Abuse
- Tuberculosis TB
- Jaw Problem TMJ/TMD

Are you allergic to any medications? Y N

Please List: _____

Are you taking any herbs or natural supplements? Y N

Please List: _____

Are you taking any medications? Y N

Please List: _____

Do you have any health problems that are not listed or need further clarification? Y N

If yes, please explain: _____

Do you smoke? Y N

If so, how much? _____

Are you taking any blood thinners? (i.e.: Aspirin) Y N

Please List: _____

- ❖ 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 care coordinator. 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, interest charges and any other expenses incurred in collecting your account.
- ❖ I understand that the fee estimate listed for this dental care can only be extended for a period of six month from the date of the patient examination.
- ❖ 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 (Patient, Parent or guardian)

Date