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We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you.

Patient Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Cell: _____ Email: _____

Social Security # _____ Birthdate: _____ Age: _____ Sex: F ☐ M ☐

Patient Employed by _____ Occupation: _____

Whom may we thank for referring you? _____ Notify in case of emergency _____
Phone : _____

Dental History

Previous Dentist: _____ Date of last dental care: _____

Do you now or have you ever experienced pain or discomfort in your jaw joint? YES ☐ NO ☐

Have you ever experienced a mouth or chin injury? YES ☐ NO ☐

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? YES ☐ NO ☐

Other information about your dental health or previous treatment _____

Medical History

Physician's name: _____ Phone: _____

Date of last visit _____ Have you had any serious illnesses or operations? _____

If yes, please describe _____

Are you currently under physician care? YES ☐ NO ☐ If yes, please describe _____

Have you ever had a blood transfusion? YES ☐ NO ☐ If yes, give approximate dates _____

Women: Are you pregnant? YES ☐ NO ☐ Nursing? YES ☐ NO ☐ Taking birth control pills? YES ☐ NO ☐ Due Date: _____

Medical History Continued (Check all that apply)

☐ AIDS/HIV Postive
☐ Anaphylaxis
☐ Arthrisis, Rheumatism
☐ Artifical heart valves
☐ Artifical Joints
☐ Asthma
☐ Atopic (allergy prone)
☐ Back problems
☐ Blood Disease
☐ Cancer
☐ Chemical Dependency
☐ Chemotherapy
☐ Circulatory Problems
☐ Cortisone treatments
☐ Cough, persistent
☐ Cough up blood
☐ Diabetes
☐ Epilepsy

☐ Fainting
☐ Food Allergies
☐ Glaucoma
☐ Headaches
☐ Heart murmur
☐ Heart problems

_____
Describe

☐ Hemophilia/Abnormal bleeding
☐ Herpes
☐ Hepatitis
☐ High Blood Pressure
☐ Kidney disease/ malfunction
☐ Liver Disease
☐ Material allergies (latex, wool, metal, chemicals)
☐ Medical Marijuana
☐ Mitral valve prolapse

☐ Nervous problems
☐ Pacemaker/Heart surgery
☐ Psychiatric care
☐ Rapid Weight loss/gain
☐ Radiation treatment
☐ Respiratory disease
☐ Rheumatic/Scarlet fever
☐ Shingles
☐ Shortness of breath
☐ Sinus problems
☐ Skin rash
☐ Spina Bifida
☐ Stroke
☐ Surgical implant
☐ Swelling feet/ankles
☐ Thyroid disease
☐ Tobacco habit
☐ Tonsillitis
☐ Tuberculosis

List any medications, if any:

_____

_____

_____

_____

_____

List any drug allergies, if any:

_____

_____

_____

Primary Insurance

Person Responsible for account: _____
Last *First* *M.I.*

Relation to Patient: _____ Birthdate: _____ Soc. Sec # _____
Address(if different) _____ Employed by: _____ Occupation: _____
Business Address _____ Business phone _____ Insurance Company _____
Subscriber ID: _____ Group #: _____ Phone: _____

Additional Insurance

Person Responsible for account: _____
Last *First* *M.I.*

Relation to Patient: _____ Birthdate: _____ Soc. Sec # _____
Address(if different) _____ Employed by: _____ Occupation: _____
Business Address _____ Business phone _____ Insurance Company _____
Subscriber ID: _____ Group #: _____ Phone: _____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there are any changes in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist 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 insurance.

Payment is due in full at time of treatment, unless prior arrangements have been approved.

Signature: _____ Date: _____