Welcome

Thank you for selection our office for your dental care. To help us meet your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us. We will be happy to help.

Soc. Sec. #_____
Date _____

Patient Information (CONFIDENTIAL)

Name_____ Birthdate _____ Home Ph._____ Cell Ph. _____

Address _____City _____State_____ Zip _____

Check appropriate box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widows ❑ Separated

If student, name of school/college_____City _____State_____ Zip _____

Patient's or parent's employer _____Work Phone _____

Business address _____City _____State_____ Zip _____

Spouse's or parent's name _____ Employer_____Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____Phone _____

Responsible Party ❑ Same as above

Name of person responsible for this account _____Relationship to patient _____

Address _____Home Phone _____

Driver's License #_____Birthdate _____Occupation _____

Employer_____Work Phone _____SSN _____

Is this person currently a patient in our office? ❑ Yes ❑ No

Insurance Information

Name of insured _____Relationship to patient_____

Birthdate_____ Social Security # _____Date Employed_____

Name of Employer_____Union or Local #_____Work Phone _____

Address or employer_____City _____State_____ Zip _____

Insurance Company_____Group _____Policy/ID # _____

Ins. co. address _____City _____State_____ Zip _____

How much is your deductible? _____ How much have you used?_____ Max. annual benefit _____

DO YOU HAVE ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING

Name of insured _____Relationship to patient_____

Birthdate_____ Social Security # _____Date Employed_____

Name of Employer_____Union or Local #_____Work Phone _____

Address or employer_____City _____State_____ Zip _____

Insurance Company_____Group _____Policy/ID # _____

Ins. co. address _____City _____State_____ Zip _____

How much is your deductible? _____ How much have you used?_____ Max. annual benefit _____

over please

Patient Medical History

Physician _____ Office Phone _____ Date of last exam_____

New Patient: Name of previous dentist and location _____

	yes	no
1. Are you under medical treatment now?	❑	❑
2. Have you been hospitalized for surgical operation or serious illness within the last 5 years?	❑	❑
If yes, please explain _____		
3. Are you taking any medications including non-prescription medicine?	❑	❑
If yes, what medications are you taking? _____		
4. Do you use tobacco?	❑	❑
5. Do you use controlled substances?	❑	❑
6. Do you have or have you had any of the following?	❑	❑

	yes	no
High blood pressure	❑	❑
Heart attack	❑	❑
Rheumatic fever	❑	❑
Swollen ankles	❑	❑
Fainting/seizures	❑	❑
Asthma	❑	❑
Low blood pressure	❑	❑
Epilepsy/convulsions	❑	❑
Leukemia	❑	❑
Diabetes	❑	❑
Kidney diseases	❑	❑
AIDS or HIV infection	❑	❑
Thyroid problem	❑	❑

	yes	no
Heart disease	❑	❑
Cardiac pacemaker	❑	❑
Heart murmur	❑	❑
Angina	❑	❑
Mitral valve prolapse	❑	❑
Anemia	❑	❑
Emphysema	❑	❑
Cancer	❑	❑
Arthritis	❑	❑
Joint replacement	❑	❑
Hepatitis/Jaundice	❑	❑
Sexually transmitted disease	❑	❑

	yes	no
Chest pains	❑	❑
Easily winded	❑	❑
Stroke	❑	❑
Hay fever/allergies	❑	❑
Tuberculosis	❑	❑
Radiation therapy	❑	❑
Glaucoma	❑	❑
Recent weight loss	❑	❑
Liver disease	❑	❑
Respiratory problems	❑	❑
Drug therapy for weight loss	❑	❑

Women: Are you pregnant?_____Nursing?_____

7. Are you allergic to or have you had any reaction to the following?

	yes	no
Local anesthetics (e.g. novocaine)	❑	❑
Penicillin or any other antibiotics	❑	❑
Sulfa drugs	❑	❑
Codeine	❑	❑
Sedatives	❑	❑

	yes	no
Iodine	❑	❑
Aspirin	❑	❑
Any metals (e.g. nickel, mercury, etc.)	❑	❑
Latex rubber	❑	❑
Other	❑	❑

Authorizationa and Release

I certify that I have read and understand the above information and have answered to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (or parent if minor) **X** _____

Health History Review

Signature_____ Date _____ Signature_____ Date _____

Signature_____ Date _____ Signature_____ Date _____

Signature_____ Date _____ Signature_____ Date _____