Welcome

Patient Information

Patient Name: ______________________________ Date: __________
Last First MI (Preferred Name)

Gender: *Male / Female* Circle one: Married Divorced Single Widowed Child

Social Security #: ____________________ Birth Date: ____________________

Phone (Home): ______________ (Work): ______________ Ext: _____ (Cell): ______________

Email address: ______________________________

Address: ______________________________
Street Apartment

____
City State Zip Code

Employer: ______________________________ Occupation ______________________________

Health Information

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/ HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints or Heart Valve
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Tuberculosis
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Osteoporosis Treatment w/ Fosamax, Boniva, Actonel, Aredia, Phen-Fen
- ☐ Pacemaker
- ☐ Kidney Disease
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tobacco Usage
- ☐ Drug Allergy
- ☐ Latex Allergy
- ☐ Premed required
- ☐ **Pregnancy**
  Due date: __________

OTHER:

- ☐ ______________
- ☐ ______________

• Current Medications and Purpose: ______________________________

____

• Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: ______________________________

• Are you now under the care of a physician? ☐ Yes ☐ No For what? ______________________________

• Name of Physician: ______________________________ Phone: ______________

• Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: ______________________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor.

______________________________ Date: ______________
Signature of patient, parent or guardian

Update: ______________________________ Date: ______________
Signature of patient, parent or guardian

Update: ______________________________ Date: ______________
Signature of patient, parent or guardian

Update: ______________________________ Date: ______________
Signature of patient, parent or guardian

Dental Health Information

Why have you come to the dentist today? ______________________________

Date of your last dental visit: ______________ Previous Dentist's Name ______________________________

Do you like your smile? ______ If not, what would you change? ______________________________

Person Responsible for Account

Name: ______________________________ Relationship to Patient ______________

☐ Male ☐ Female

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): ______________ (Work): ______________ Ext: ______ (Cell): ______________

Address: ____
Street Apartment #

____
City State Zip Code

Insurance Information

Primary

Name of Insured: ______________________________ Relationship to Patient ______________
Last First MI

Insured's Birth Date: ______________ SS #: ______________ Group #: ______________

Insured's Employer Name: ______________________________

Secondary

Name of Insured: ______________________________ Relationship to Patient ______________
Last First MI

Insured's Birth Date: ______________ SS #: ______________ Group #: ______________

Insured's Employer Name: ______________________________

If this office accepts my insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature ______________________________ Date ______________

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ School ☐ Work ☐ Internet Name ______________________

Consent for Services

To the best of my knowledge, the information provided is true and correct. I understand that it will be held in the strictest confidence and only be used to improve communication between the doctor and myself. I also give permission for the doctor or his staff to use any photos he may take to be used for lecturing and education purposes.

Signature ______________________________ Date ______________ Relationship to Patient ______________