

Welcome to our office. We thank you for choosing us as your dentist, and we are very happy to have you as our patient.

Please fill out both pages of this form to ensure proper and thorough treatment.

Patient's Name \_\_\_\_\_

Adult     Child     Single     Married     Divorced     Widowed

Name of Spouse (If Married) \_\_\_\_\_

Home Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Number(    ) \_\_\_\_\_

**Patient(or Father\*)**

Employed By \_\_\_\_\_ Business Phone Number(    ) \_\_\_\_\_

Business Address \_\_\_\_\_

Position \_\_\_\_\_ How long held? \_\_\_\_\_

Social Security No. \_\_\_\_\_ Date of Birth \_\_\_\_\_

Driver's Liscence# (if payment is to be made by any other method but cash) \_\_\_\_\_

**Spouse (if married or Mother\*)**

Employed By \_\_\_\_\_ Business Phone Number(    ) \_\_\_\_\_

Business Address \_\_\_\_\_

Position \_\_\_\_\_ How long held? \_\_\_\_\_

Social Security No. \_\_\_\_\_ Date of Birth \_\_\_\_\_

Driver's License# (if payment is to be made by any other method but cash) \_\_\_\_\_

Name of closest relative or friend not living with you, whom we can notify in case of emergency \_\_\_\_\_

    Their home Phone No. (    ) \_\_\_\_\_ Their work Phone No.(    ) \_\_\_\_\_

    Address \_\_\_\_\_

What is the purpose of this appointment? \_\_\_\_\_

Who will pay for this account? \_\_\_\_\_

By which method will you settle your account TODAY and future visits?

Cash     Check     Dental Insurance & Copayment

Credit Card     Visa     Master Card     Amex     Discover    Card No. \_\_\_\_\_

Sorry, there is no billing in our office. Payment must be made when services are rendered unless prior arrangements have been made.

If you have Dental Insurance, what is the Group Name? \_\_\_\_\_ Group No \_\_\_\_\_

The I.D. No. or SS No. \_\_\_\_\_ Please supply us with appropriate forms.

How did you find out about us? Referral by (Name) \_\_\_\_\_

Telephone Directory     Other \_\_\_\_\_

Comments \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Are you under medical treatment at this time?  Yes If yes, explain, \_\_\_\_\_

No \_\_\_\_\_

Name of Medical Physician \_\_\_\_\_ Address \_\_\_\_\_

Last Physical Exam \_\_\_\_\_ Telephone # \_\_\_\_\_

Are you allergic to or have you ever had an adverse reaction to Penicillin, Codeine or any other drugs or medicine?

Yes  No If yes, what \_\_\_\_\_

Has a physician ever informed you that you had or have any of the following:

\_\_\_\_ Heart Aliment                      \_\_\_\_ Diabetes                      \_\_\_\_ Hepatitis or Jaundice

e.g.Murmur, Artery Blockage      \_\_\_\_ Liver Disease                      \_\_\_\_ Acquired Immune Deficiency Syndrome (AIDS)

Mitral Valve Proplapse                      \_\_\_\_ Kidney Aliment                      \_\_\_\_ Tumors or Growths

\_\_\_\_ High Blood Pressure                      \_\_\_\_ Stomach or                      \_\_\_\_ Epilepsy

\_\_\_\_ Rheumatic Heart Fever                      Intestinal Problems                      \_\_\_\_ Venereal Disease

\_\_\_\_ Any Blood Disease

Are you on a special doctor's diet? \_\_\_\_\_

Are you taking any drugs or medications?  Yes  No

If yes, what \_\_\_\_\_

Are you allergic to any known materials?  Yes  No

If yes, what \_\_\_\_\_

(Women) Are you pregnant?  Yes  No

Do you have a history of fainting? \_\_\_\_\_

### **DENTAL HISTORY**

Have you had dental anesthesia before?  Yes  No

If yes, any adverse reactions \_\_\_\_\_

Do your gums bleed? \_\_\_\_\_

Have you had instructions on the correct method of brushing your teeth and care of your gums? \_\_\_\_\_

When was your last cleaning and check-up done? \_\_\_\_\_

When did you last have a full set of x-rays (10-18 films) taken? \_\_\_\_\_

Do you have any dental complaints or comments at this time? \_\_\_\_\_

I Herby state that all the above information is correct, and I am fully responsible for all fees incurred and not covered by any insurance payment.

Signature of Patient (or Parent) \_\_\_\_\_ Date \_\_\_\_\_

Please notify us if there are any changes in any of the above information.

THANK YOU, WE APPECIATE YOUR COOPERATION