Welcome to our practice!

Please fill out th[illegible]m and return it to our front desk. Thank you!

Patients Name _____ SS# _____
Last First M.I. (Jr. Sr. III etc.)

I would prefer to be called (nickname, etc.)_____ (Kids Only) Male____ Female____

Address _____
Street & Number City State ZIP Code

Date of Birth _____/_____/_____ Pager/Cellular/Other #_____
Month Day Year

Home Phone #_____ Work Phone #(incl. Ext. as needed)_____

Please circle if you have now or have had any of the follwing:

Heart Murmur	**High Blood Pressure**	**Epilepsy**	**Tumor or Cancer**	**Arthritis**
Mitral Valve Prolapse	**Heart Disease**	**Diabetes**	**Radiation Therapy**	**HIV+ / AIDS**
Rheumatic Fever	**Heart Attack**	**Asthma**	**Hay Fever**	**Anemia**
Artificial Joints	**Chronic Lung Disease**	**Stroke**	**Veneral Disease**	**Hepatitis**
Artificial Heart Valves	**Psychiatric Care**	**Tuberculosis**	**Fainting Spells**	**Pacemaker**

Any other serious disease/conditon not listed:_____

Within the last 6 months have you taken (circle): **digitalis, cortisone (steroids), tranquilizers, blood pressure medicine, insulin, anti-depressants, anticoagulants (blood thinners) or nitroglycerine.**

Are you allergic to any medication? **Penicillin, Aspirin, Sulfa, Codeine, other**_____

Are you allergic to any material? **Latex, Nickel, Dental Anesthetic, other**_____

Are you regularly taking any prescription or over the counter medications? **Aspirin, Tylenol, Ibuprofen, other**_____

_____

Who is your present physician: _____ Telephone #_____

Please list hospitilizations over the past 5 years (other than childbirth):_____

_____

Women -Are you or might you be pregnant now? Yes No If yes, what is your due date:_____
-Are you taking Birth Control pills?

_____

Do you have any pain or problems with your teeth or mouth? Yes No
If yes, please describe_____

Have you ever had excessive bleeding following a tooth extraction or other injury ? Yes No

Do your gums bleed when brushing or flossing? Yes No
If yes, where_____

Have you ever fainted or had a "bad experience" in a dental office ? Yes No
If yes, describe_____

Do you use tobacco products (cigarettes, dip, cigar, pipe)? Yes No
If yes, how much per day_____ For how long (months/years)_____

When was your last visit to a Dentist?_____ Was this an emergency visit? Yes No

Were X-rays taken? Yes No Don't Know

Are you happy with your smile and overall look of your teeth? Yes No
If no, would you like to discuss possible ways to improve your smile with the Dentist ? Yes No

How were you referred to our office? Family/Friend_____ Verizon Yellow Pages_____
Office Sign_____ Other_____ Yellow Book USA _____

Thank you for filling out this form completely as it enables us to assist you more effectively.
If you have ANY questions at this time, please ask us and we will be happy to help.

As a courtesy, we will file insurance forms for your primary dental insurance carrier on your behalf. Please understand if there are any differences between the fee charged and the amount your insurance carrier reimburses under your plan, those differences are strictly between you and your dental insurance company.
The patient (or legally responsible adult) is responsible for all fees, regardless of insurance coverage. Payment is expected at the time service (dental treatment) is rendered, unless prior written arrangements have been made with our office.

I have seen and agree to the terms of the Late Cancellation/Failed Appointment Policy.

The information given above is correct to the best of my knowledge. I agree to comply with office payment policy.
I understand this information will be held in the strictest confidence by this office.

Patient's/Parent's Signature_____ **Date**_____