# Welcome

We are pleased to welcome you to our practice. Please take a few moments to complete **both sides** of this form.
If you have questions, we'll be glad to help you.

## Patient Information

Name ______________________________ Nickname ______________
*Last* *First* *Middle*

Address ______________________________ Soc. Sec. # ______________

City ______________ State ______ Zip ________ Home Phone ______________

Birthdate ______________ Age ________ Sex ❑ M ❑ F Cell Phone ______________

❑ Minor ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced Fax ______________

Employer/Occupation ______________________________ Work Phone ______________

Business Address ______________________________

Full-time students: Name of School/College ______________ City/State ______________

Whom may we thank for referring you? ______________________________

Notify in case of emergency ______________ Home Phone ______________ Work Phone ______________

***Person Responsible for Account (if patient is a minor)***

Name ______________________________ Soc. Sec. # ______________
*Last* *First* *Middle*

Address ______________________________ Phone ______________

Relation to Patient ______________ Birthdate ______________ Age ________ DL # ______________

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced Sex ❑ M ❑ F

Employer ______________________________ Work Phone ______________

## Insurance Information

***Primary Insurance***

Name of Subscriber ______________________________
*Last* *First* *Middle*

Relation to Patient ______________ Birthdate ______________ Soc. Sec. # ______________

Address (if different from patient) ______________________________

Employer ______________________________ Work Phone ______________

Employer's Address ______________________________

Insurance Company ______________________________ Phone ______________

Group Name or Number ______________________________ Union/Local # ______________

***Secondary Insurance***

Name of Subscriber ______________________________
*Last* *First* *Middle*

Relation to Patient ______________ Birthdate ______________ Soc. Sec. # ______________

Address (if different from patient) ______________________________

Employer ______________________________ Work Phone ______________

Employer's Address ______________________________

Insurance Company ______________________________ Phone ______________

Group Name or Number ______________________________ Union/Local # ______________

## Dental History

Reason for Today's Visit ____________________

Former Dentist ____________ Phone ____________ Date of last dental x-rays ____________

Check (✓) if you have any of the following:

- ❑ Bad Breath
- ❑ Bleeding gums
- ❑ Clicking or popping jaw
- ❑ Grinding teeth
- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Food collection between teeth
- ❑ Sores or growths in your mouth
- ❑ Sensitivity

## Medical History

Physician's Name (or Facility Name) ____________________ Phone ____________

If Kaiser: Account holder (who receives the bill) ____________________

Account holder's MR# ____________ Soc. Sec. # ____________ Patient's MR# ____________

Have you had any serious illnesses or operations? ❑N ❑Y Describe: ____________________

Women: Are you pregnant? ❑N ❑Y Nursing? ❑N ❑Y Taking Birth Control Pills? ❑N ❑Y

Check (✓) if you have had any of the following:

Date

- _____ ❑ Artificial joints
- _____ ❑ Kidney disease
- _____ ❑ Rheumatic/Scarlet Fever
- _____ ❑ Heart murmur
- _____ ❑ Heart pacemaker
- _____ ❑ Artificial heart valve
- _____ ❑ Other heart condition
  Describe ____________
  ____________
- _____ ❑ Hemophilia
- _____ ❑ Latex allergy
- _____ ❑ Diabetes
- _____ ❑ Jaw pain
- _____ ❑ Sinus trouble
- _____ ❑ Fainting/dizzy spells
- _____ ❑ Liver disease
- _____ ❑ Chemical dependency
- _____ ❑ Thyroid disease
- _____ ❑ Glaucoma
- _____ ❑ Heart attack
- _____ ❑ Cancer
- _____ ❑ Chemotherapy/Radiation
- _____ ❑ Arthritis, Rheumatism
- _____ ❑ Cortisone treatments
- _____ ❑ Ulcers
- _____ ❑ Anemia/Sickle Cell Disease
- _____ ❑ Angina Pectoris
- _____ ❑ Emphysema
- _____ ❑ Hepatitis
- _____ ❑ Tuberculosis
- _____ ❑ Blood transfusion
- _____ ❑ AIDS/HIV positive
- _____ ❑ Stroke
- _____ ❑ Hay fever
- _____ ❑ Herpes
- _____ ❑ Psychiatric care
- _____ ❑ Tobacco habit
- _____ ❑ High Blood Pressure
- _____ ❑ Asthma
- _____ ❑ Epilepsy/seizures

***List all medications you are currently taking:***

____________________
____________________
____________________

***List drug allergies:***

____________________
____________________
____________________

**Medical History Update (for office use)**

| Date | Comments | Signature |
| --- | --- | --- |
| 1. ________ | ____________________ | ____________ |
| 2. ________ | ____________________ | ____________ |
| 3. ________ | ____________________ | ____________ |

## Authorization & Release

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my medical status.
I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all my insurance submissions. I hereby authorize the dentist to release all information necessary to secure the payment of benefits.
I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment.

Signature ____________________ Date ____________