

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:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Food collection between teeth |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sores or growths in your mouth |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> 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:

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