

# WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

## PATIENT INFORMATION

Date \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Permission to Call  Yes  No  
Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Last Name First Name Initial  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  Married  Widowed  Divorced  
Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_ Permission to Call  Yes  No  
How were you referred to our office?  Western Hills/Price Hill Press  Yellow Pages  Pink Pages  Other (give name) \_\_\_\_\_  
Name and phone number of nearest relative not living with you \_\_\_\_\_ Phone \_\_\_\_\_

## RESPONSIBLE PARTY AND / OR PRIMARY DENTAL INSURANCE

Person Responsible for Account \_\_\_\_\_  
Last Name First Name  
Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address (If different from patient's) \_\_\_\_\_ Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Subscriber Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_

## SECONDARY INSURANCE

Is patient covered by additional insurance?  Yes  No  
Subscriber Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
Subscriber Birthdate \_\_\_\_\_ Subscriber's SS# \_\_\_\_\_  
Address (If different from patient's) \_\_\_\_\_ Phone \_\_\_\_\_  
Subscriber Employed by \_\_\_\_\_ Business Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_

PLEASE COMPLETE BOTH SIDES

## DENTAL HISTORY

Reason for Today's Visit \_\_\_\_\_

Are you experiencing any dental discomfort?  Yes  No If yes, describe \_\_\_\_\_

Date of last dental visit \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_

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

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Bad Breath                    | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to cold     |
| <input type="checkbox"/> Bleeding gums                 | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity to hot      |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sores or growths in your mouth | <input type="checkbox"/> Sensitivity to sweets   |
|  |   | <input type="checkbox"/> Sensitivity when biting |

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Have you had any serious illness or operations?  Yes  No If yes, describe \_\_\_\_\_

(Women) Are you pregnant?  Yes  No Nursing?  Yes  No Taking birth control pills?  Yes  No

Are you currently taking any pills or medications?  Yes  No

If yes, List Med \_\_\_\_\_ Dosage \_\_\_\_\_ Use For \_\_\_\_\_  
 \_\_\_\_\_ Dosage \_\_\_\_\_ Use For \_\_\_\_\_  
 \_\_\_\_\_ Dosage \_\_\_\_\_ Use For \_\_\_\_\_

Have you had an allergic reaction to any medicine?  Yes  No If yes, describe \_\_\_\_\_

Have you had an allergic reaction to latex?  Yes  No Do you smoke?  Yes  No Do you use smokeless tobacco?  Yes  No  
 How much/day \_\_\_\_\_ For how long \_\_\_\_\_

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

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> AIDS/HIV Positive         | <input type="checkbox"/> Chemotherapy                | <input type="checkbox"/> Heart Problems        | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Alzheimers                | <input type="checkbox"/> Circulatory Problems        | Describe _____                                 | <input type="checkbox"/> Rheumatic Fever     |
| <input type="checkbox"/> Anaphylaxis               | <input type="checkbox"/> Cortisone Treatments        | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Sinusitis           |
| <input type="checkbox"/> Arthritis, Rheumatism     | <input type="checkbox"/> Cough, Persistent or Bloody | <input type="checkbox"/> Hepatitis A, B or C   | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Artificial Heart Valves   | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Thyroid Problems    |
| <input type="checkbox"/> Artificial Joints         | <input type="checkbox"/> Drug/Alcohol Addiction      | <input type="checkbox"/> Kidney Problems       | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Epilepsy/Seizures           | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Tumors/Prostate     |
| <input type="checkbox"/> Back Problems             | <input type="checkbox"/> Fainting                    | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Ulcer               |
| <input type="checkbox"/> Blood Disease/Transfusion | <input type="checkbox"/> Glaucoma                    | <input type="checkbox"/> Pancreas              | <input type="checkbox"/> Venereal Disease    |
| <input type="checkbox"/> Blood Pressure High/Low   | <input type="checkbox"/> Headaches                   | <input type="checkbox"/> Psychological Care    |  |
| <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Heart Murmur                | <input type="checkbox"/> Radiation Treatment   |  |

Describe \_\_\_\_\_

## AUTHORIZATION

**I understand that I am financially responsible for all charges whether or not paid by insurance and am responsible for all collection fees.**

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

Signature \_\_\_\_\_ Date \_\_\_\_\_