Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # ______________
Soc.Sec. # ______________
Date ______________

Patient Information (CONFIDENTIAL)

Name ______________ *Birthdate* ______________ *Home Phone* ______________
Address ______________ *City* ______________ *State* ______ *Zip* ______
Check Appropriate Box: ☐ *Minor* ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Separated*
Patient's or Parent's Employer ______________ *Work Phone* ______________
Business Address ______________ *City* ______________ *State* ______ *Zip* ______
Spouse or Parent's Name ______________ *Employer* ______________ *Work Phone* ______________
If Patient is a Student, Name of School/College ______________ *City* ______________ *State* ______
Whom May We Thank for Referring You? ______________
Person to Contact in Case of Emergency ______________ *Phone* ______________

Responsible Party

Name of Person Responsible for this Account ______________ *Relationship to Patient* ______________
Address ______________ *Home Phone* ______________
Driver's License # ______________ *Birthdate* ______________ *Financial Institution* ______________
Employer ______________ *Work Phone* ______________
Is this Person Currently a Patient in our Office? ☐ *Yes* ☐ *No*

Insurance Information

Name of Insured ______________ *Relationship to Patient* ______________
Birthdate ______________ *Social Security #* ______________ *Date Employed* ______________
Name of Employer ______________ *Work Phone* ______________
Address of Employer ______________ *City* ______________ *State* ______ *Zip* ______
Insurance Company ______________ *Group #* ______________ *Union or Local #* ______________
Ins. Co. Address ______________ *City* ______________ *State* ______ *Zip* ______
How Much is your Deductible? ______________ *How Much Have You Used?* ______________ *Max. Annual Benefit* ______________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ *Yes* ☐ *No* *IF YES, COMPLETE THE FOLLOWING:*

Name of Insured ______________ *Relationship to Patient* ______________
Birthdate ______________ *Social Security #* ______________ *Date Employed* ______________
Name of Employer ______________ *Work Phone* ______________
Address of Employer ______________ *City* ______________ *State* ______ *Zip* ______
Insurance Company ______________ *Group #* ______________ *Union or Local #* ______________
Ins. Co. Address ______________ *City* ______________ *State* ______ *Zip* ______
How Much is your Deductible? ______________ *How Much Have You Used?* ______________ *Max. Annual Benefit* ______________

Over Please

PATIENT MEDICAL-DENTAL HISTORY

Physician ____

Approximate date of last physical examination ____________________________

		Yes	No
1.	Are you under any medical treatment now?	☐	☐
2.	Have you had any major operations? If so what?	☐	☐
3.	Have you ever had a serious accident involving head injuries?	☐	☐
4.	Have you had any adverse response to any drugs including penicillin?	☐	☐
5.	Has a physician ever informed you that you had: A Heart Ailment?	☐	☐
6.	High blood pressure?	☐	☐
7.	Respiratory disease?	☐	☐
8.	Diabetes?	☐	☐
9.	Rheumatic fever?	☐	☐
10.	Rheumatism or arthritis?	☐	☐
11.	Tumors or growths?	☐	☐
12.	Any blood disease?	☐	☐
13.	Any liver disease?	☐	☐
14.	Any kidney disease?	☐	☐
15.	Any stomach or intestinal disease?	☐	☐
16.	Any venereal disease?	☐	☐
17.	Yellow jaundice or hepatitis?	☐	☐
18.	Do you have night sweats accompanied by weight loss or cough?	☐	☐
19.	Are you on a diet at this time?	☐	☐
20.	Are you now taking drugs or medications?	☐	☐
21.	Are you allergic to any known materials resulting—in hives, asthma, eczema, etc	☐	☐
22.	Are you in general good health at this time?	☐	☐
23.	Have any wounds healed slowly or presented other complications?	☐	☐
24.	Are you pregnant?	☐	☐
25.	Do you have a history of fainting?	☐	☐
26.	Have you ever had any X-RAY TREATMENTS (other than diagnostic)?	☐	☐
27.	Do you have Aids or Aids related complex?	☐	☐
28.	Have you ever tested positive for HIV?	☐	☐
29.	Have you ever been treated for drug dependency?	☐	☐

PATIENT DENTAL HISTORY

		Yes	No
30.	Do you have pain in or near your ears?	☐	☐
31.	Do you have any unhealed injuries or inflamed areas in or around your mouth?	☐	☐
32.	Have you experienced any growth or sore spots in your mouth?	☐	☐
33.	Does any part of your mouth hurt when clenched?	☐	☐
34.	Have you ever had Novocaine anesthetic?	☐	☐
35.	Any reactions or allergic symptoms to novocaine?	☐	☐
36.	Any difficult extractions in the past?	☐	☐
37.	Prolonged bleeding following extract in the past?	☐	☐
38.	Trench Mouth?	☐	☐
39.	Do your gums bleed?	☐	☐
40.	Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
41.	Have you ever had instruction on the care of your gums?	☐	☐
42.	Do you chew on only one side of your mouth? If so, why?	☐	☐
43.	Do you at the present time have any dental complaints?	☐	☐
44.	Do you habitually clench your teeth during the night or day?	☐	☐
45.	When was your last full mouth X-Ray taken?____________ Where?____________	☐	☐
46.	Any part of your mouth sore to pressures or irritants (cold, sweets, etc.)?	☐	☐
47.	If so locate ____________________	☐	☐

Signature____________________________