WELCOME
TO OUR PRACTICE

Please take a few minutes to answer the following questions so we can better assist you with your dental care needs.

PATIENT INFORMATION

Today's Date ______________ Birth Date ______________ Patient Social Security # ______________

Patient Name ______________ (Last Name) ______________ (First Name) ______________ (Initial)

Street Address ______________

City ______________ State ______________ Zip ______________

Occupation ______________ ❒ Male ❒ Female ❒ Single ❒ Married ❒ Widowed ❒ Divorced ❒ Separated

Patient Home Phone ______________ Patient Work Phone ______________

Employer ______________ Employer Phone ______________

Employer Address ______________

In Case Of Emergency Contact:

Name ______________ Relationship ______________

Emergency Home Phone ______________ Emergency Work Phone ______________

Whom may we thank for referring you to us? ______________

PRIMARY INSURANCE

Individual responsible for this account ______________ (Last Name) ______________ (First Name) ______________ (Initial)

Relationship to Patient ______________ Birth Date ______________ Social Security # ______________

Street Address ______________ Home Phone ______________

City ______________ State ______________ Zip ______________

Responsible Party Employed By ______________ Business Phone ______________

Business Address ______________ Occupation ______________

Insurance Company ______________

Insurance Company Address ______________

Subscriber I.D. # ______________ Group # ______________

ADDITIONAL INSURANCE

Insured Individual's Name ______________ (Last Name) ______________ (First Name) ______________ (Initial)

Relationship to Patient ______________ Birth Date ______________ Social Security # ______________

Street Address ______________ Home Phone ______________

City ______________ State ______________ Zip ______________

Insured Party Employed By ______________ Business Phone ______________

Insurance Company ______________

Insurance Company Address ______________

Subscriber I.D. # ______________ Group # ______________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ______________ and assign directly to Dr. ______________ all insurance benefits, for any services provided me. I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company, any other third party payer, state medical assistance agency, or any other governmental or private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for related services. I agree to pay for all charges not covered by a third party payer. I authorize a copy of this authorization to be used in place of the original. In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referral physician, and/or the provider, if any, who referred me here. I expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered without obtaining my signature on each nd every claim submitted.

Signature ______________ Date ______________

FAMILY HEALTH INFORMATION

Some health conditions are the result of hereditary spinal weaknesses. Information that you can furnish us pertaining to your immediate family members (brothers, sisters, parents and grandparents) will give us a better understanding of your total health needs.

RELATIONSHIP TO YOU	HEALTH PROBLEMS ANY FAMILY MEMBER HAS HAD OR HAS NOW

MEDICATIONS

List medications you are currently taking

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____

____

Pharmacy ________________________ Phone ____________

- ❑ Aspirin
- ❑ Barbiturates
- ❑ Codeine
- ❑ Iodine
- ❑ Latex
- ❑ Local Anesthetic
- ❑ Penicillin
- ❑ Sulfa
- ❑ Other (please list)

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CHECK ANY SYMPTOM(S) OR CONDITION(S) BELOW THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR:

- ❑ AIDS
- ❑ Appendicitis
- ❑ Arm Pain or Numbness
- ❑ Arthritis
- ❑ Asthma
- ❑ Back Pain or Numbness
- ❑ Bleeding Disorders
- ❑ Bleeding Gums
- ❑ Bloating
- ❑ Blood in Urine
- ❑ Blurred Vision
- ❑ Bowel Changes
- ❑ Breast Lump
- ❑ Brights Disease
- ❑ Bruise Easily
- ❑ Bursitis
- ❑ Cancer
- ❑ Cataracts
- ❑ Change in Moles
- ❑ Chemical Dependency
- ❑ Chest Pain
- ❑ Chicken Pox
- ❑ Chills
- ❑ Constipation
- ❑ Crossed Eyes
- ❑ Diabetes
- ❑ Diarrhea
- ❑ Depression/Nervousness
- ❑ Difficulty Swallowing
- ❑ Dizziness/Fainting
- ❑ Double Vision
- ❑ Excessive Thirst
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Earache
- ❑ Ear Discharge
- ❑ Feet Pain or Numbness
- ❑ Fever
- ❑ Forgetfulness
- ❑ Frequent Urination
- ❑ Gas
- ❑ Glaucoma
- ❑ Hand Pain or Numbness
- ❑ Hay Fever
- ❑ Headache
- ❑ Heart Disease
- ❑ Hemorrhoids
- ❑ Hepatitis
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Hip Pain or Numbness
- ❑ HIV Positive
- ❑ Hives
- ❑ Hoarseness
- ❑ Indigestion
- ❑ Irregular Heartbeat
- ❑ Itching
- ❑ Jaundice
- ❑ Kidney Disease
- ❑ Lack of Bladder Control
- ❑ Leg Pain or Numbness
- ❑ Liver Disease
- ❑ Loss of Hearing
- ❑ Loss of Sleep
- ❑ Loss of Weight
- ❑ Low Blood Pressure
- ❑ Lumbago
- ❑ Measles
- ❑ Migraine Headaches
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Nausea
- ❑ Neck Pain or Numbness
- ❑ Neuralgia
- ❑ Neuritis
- ❑ Nose Bleeds
- ❑ Pacemaker
- ❑ Painful Urination
- ❑ Persistent Cough
- ❑ Pneumonia
- ❑ Polio
- ❑ Poor Appetite
- ❑ Poor Circulation
- ❑ Prostate Problem
- ❑ Rapid Heartbeat
- ❑ Rash
- ❑ Rectal Bleeding
- ❑ Rheumatic Fever
- ❑ Ringing in Ears
- ❑ Scarlet Fever
- ❑ Scars
- ❑ Sciatica
- ❑ Shoulder Pain or Numbness
- ❑ Sinus Problems
- ❑ Sore That Won't Heal
- ❑ Stomach Aches or Pains
- ❑ Stroke
- ❑ Sweats
- ❑ Swelling Ankles
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Varicose Veins
- ❑ Venereal Disease
- ❑ Vision Flashes
- ❑ Vomiting
- ❑ Vomiting Blood

CHECK DEGREE OF HABITS BELOW. ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL.

	HEAVY	CASUAL	LIGHT	NONE
Alcohol	❑	❑	❑	❑
Appetite	❑	❑	❑	❑
Artificial Sweeteners	❑	❑	❑	❑
Coffee	❑	❑	❑	❑

	HEAVY	CASUAL	LIGHT	NONE
Drugs	❑	❑	❑	❑
Exercise	❑	❑	❑	❑
Salty Foods	❑	❑	❑	❑
Sleep	❑	❑	❑	❑

	HEAVY	CASUAL	LIGHT	NONE
Soft Drinks	❑	❑	❑	❑
Sugar/Sugar Products	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑
Water	❑	❑	❑	❑

I certify that the above information is correct to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature ____________________________________ Date ________________