WELCOME

The benefits of a happy, healthy smile are immeasurable!
Our goal is to help you reach
and maintain maximum oral health.
Please fill out this form completely.
The better we communicate, the better we can care for you.

1 ABOUT YOU

Name: _____

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: _____ Age: _____ SS #: _____

Home Address: _____

_____
City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home #: _____ Cell phone #: _____

WK #: _____ Ext: _____

Employer

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Who may we **Thank** for referring you? _____

Other family members seen by us: _____

Previous/Present Dentist: _____
(Please Circle)

Last Visit Date: _____

2 DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

ID #: _____

Insured's Name: _____ Relation: _____

Insured's Birthday: _____ Insured's SS #: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

ID #: _____

Insured's Name: _____ Relation: _____

Insured's Birthday: _____ Insured's SS #: _____

Insured's Employer: _____

3 SPOUSE INFORMATION

Spouse's Name _____

Employer: _____

WK #: _____ Ext _____ SS #: _____

Birthdate: _____

Person Responsible for Account: _____

WK #: _____ Ext _____ Home #: _____

Billing Address: _____

Relationship: _____ SS #: _____

Employer: _____ DL #: _____

4 MEDICAL HISTORY

Do you have a personal physician? ☐ No ☐ Yes

Physician's Name: _____

Phone #: _____ Date of last visit: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____ Relation: _____

WK #: _____ Home #: _____

4 Medical History Continued

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ No ☐ Yes

Please explain: _____

Are you taking any prescription / over-the-counter drugs? ☐ No ☐ Yes

Please list each one _____

_____

For Women Are you taking birth control pills? ☐ No ☐ Yes

Are you pregnant? ☐ No ☐ Yes Week # _____

Are you nursing? ☐ No ☐ Yes

Have you ever had any of the following diseases or medical problems?

Y N	Heart Attack / Stroke	Y N	Psychiatric Problems
Y N	Cancer / Chemotherapy	Y N	Epilepsy / Seizures / Fainting Spells
Y N	Heart Murmur	Y N	Diabetes / Tuberculosis (TB)
Y N	Rheumatic Fever	Y N	Drug / Alcohol Abuse
Y N	HIV+ / AIDS	Y N	Venereal Disease
Y N	Heart Surgery / Pacemaker	Y N	Hemophilia / Abnormal Bleeding
Y N	Shingles	Y N	Ulcers / Colitis
Y N	Mitral Valve Prolapse	Y N	Congenital Heart Defect
Y N	Kidney Problems	Y N	Anemia / Radiation Treatment
Y N	Joint / Valve Replacement	Y N	Asthma / Arthritis
Y N	Artificial Valves	Y N	Difficulty Breathing
Y N	Sinus Problems	Y N	Hospitalized for Any Reason
Y N	High / Low Blood Pressure	Y N	Hepatitis
Y N	Fever Blisters	Y N	Blood Transfusion
Y N	Severe / Frequent Headaches	Y N	Emphysema / Glaucoma

Please list any serious medical condition(s) that you have ever had:

_____

Are you allergic to any of the following drugs?

Y N Penicillin	Y N Tetracycline	Y N Latex
Y N Aspirin	Y N Dental Anesthetics	Y N Other
Y N Erythromycin	Y N Codeine	

Please list any other drugs that you are allergic to: _____

_____

5 Dental History

Why have you come to the dentist today?

_____

_____

Are you currently in pain? ☐ No ☐ Yes

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ No ☐ Yes

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ No ☐ Yes

Your current dental health is

☐ Good ☐ Fair ☐ Poor

Do you like your smile?

☐ No ☐ Yes

Do your gums ever bleed?

☐ No ☐ Yes

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of bristles?

☐ Hard ☐ Medium ☐ Soft

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform, with my informed consent, any necessary dental services I may need during diagnosis and treatment.

If you have dental insurance, your deductible and patient portion is due on date of service. Please keep in mind that we can only estimate your insurance and it is not a guarantee of payment. You are responsible for any balance. If you are sending a minor child in by themselves or with a friend or relative, you will need to send payment with them.

If there is any remaining balance after your insurance company pays, the balance is due upon receipt of statement. A service charge of 1.5% will be added after 30 days on any unpaid balance and will be assessed each month. Failure to keep this account current may result in our being unable to provide additional dental services to you except for dental emergencies or you may be required to pre-pay for any future services. In the case of default of payment on this account, you will be responsible for and billed for all collection costs, court fees and attorney fees incurred in collecting this amount or any future outstanding account balances.

Signature _____ Date _____

Payment is due in full at the time of treatment unless prior arrangements have been made.