Welcome

We are pleased to welcome you and/or your child 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

Patient Name ______________________ Sex M F

Birthdate ______________________ Age ______________________

Address ______________________ SS# ______________________

City ______________________ Spouse's Name ______________________

State ________ Zip ______________ Spouse's Employer ______________________

Patient Employer ______________________

Please Check One

☐ Married ☐ Single ☐ Minor ☐ College ☐ Other

Whom may we thank for referring you? ______________________

Phone Numbers

Home ____________ Work ____________ Ext ________ Cell ____________

Spouse's Work ____________ Cell ____________ Best time and place to reach you ____________

How would you like to be reminded of appointments? ☐ Text ☐ E-mail ☐ Phone

E-mail Address ______________________

In case of emergency, contact (Specify someone who does not live in your household.)

Name ______________________ Relationship ______________________

Home Phone ____________ Work Phone ____________ Cell Phone ____________

MEDICATIONS

PHARMACY:___________________________________

PHYSICIAN:____________________________________

CURRENT MEDICATIONS:

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DENTAL HISTORY

Reason for today's visit ____

Former Dentist ________________________ City/State ____________________

Date of last dental visit ______________________ Date of last Dental X-rays ____________

How often do you floss? ______________________ How often do you brush? ____________

Do you wear contact lenses? YES OR NO

Please circle YES or NO to indicate if you have had any of the following:

Bad breath	Yes	No	Jaw pain or tiredness	Yes	No
Bleeding gums	Yes	No	Lip or cheek biting	Yes	No
Blisters on lips/ mouth	Yes	No	Loose teeth or broken fillings	Yes	No
Burning sensation on tongue	Yes	No	Mouth breathing	Yes	No
Chew on one side of mouth	Yes	No	Mouth pain	Yes	No
Cigarette, pipe, or cigar smoking	Yes	No	Orthodontic treatment	Yes	No
Clicking or popping jaw	Yes	No	Pain around ear	Yes	No
Dry mouth	Yes	No	Periodontal treatment	Yes	No
Fingernail biting	Yes	No	Sensitivity to cold	Yes	No
Food collection between teeth	Yes	No	Sensitivity to heat	Yes	No
Foreign objects in mouth	Yes	No	Sensitivity to sweets	Yes	No
Grinding teeth	Yes	No	Sensitivity when biting	Yes	No
Gums swollen or tender	Yes	No	Sores or growths in mouth	Yes	No

ALL FAMILY MEMBERS WILL BE PLACED ON THE SAME ACCOUNT UNLESS SPECIFIED OTHERWISE BEFORE TREATMENT IS INITIATED

Dental Insurance

Primary Insurance

Subscriber's Name _________________________ Relationship to Patient_____________________________

Insurance Co. ______________________________ Birthdate ____________ SS# ________________________

Patient ID # _______________________________ Group #____________________ Phone#_____________

Is patient covered by **SECONDARY INSURANCE**? Yes No

Subscriber's Name _________________________ Relationship to Patient_____________________________

Insurance Co. ______________________________ Birthdate ____________ SS# ________________________

Patient ID # _______________________________ Group #____________________ Phone#_____________

Insurance Assignment: **I certify that I, and/or my dependent(s), have insurance coverage with __________________________and assign directly to Dr.________________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.**

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from date signed below.

____ ____
Signature **Date**