Welcome to our Dental Practice

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Thank you for choosing us as your dental provider

Patient Information

Patient Name_____ Date of Birth_____/____/_____
Male____ Female____ Single____ Married____ Divorce____ Widowed____
Home Address_____ City_____ Zip Code_____
Home Phone ( )_____ Cell Phone ( )_____ Work ( )_____
Social Security #_____ Driver's License #_____

Insurance Information

Name of the Insured_____ Date of birth _____/_____/_____
Billing Address_____ City_____ State____ Zip Code_____
Home Phone ( )_____Cell Phone( )_____ Work Phone ( )_____
Social Security #_____ Driver's License #_____
Employer_____ Employer Start Date_____
Employer Address _____ City _____State_____ Zip Code_____
Insurance Company_____ Group #_____ Local #_____
Insurance Co. Address_____ City _____State_____ Zip Code_____
Insurance Coverage (check all that apply) Self ☐ Spouse ☐ Children ☐ Other(s) _____
Relationship if "others" is checked above_____

Dental History

Reason for today's visit_____ Date of last Dental Cleaning_____
Former Dentist_____ Date of last Dental X-Rays_____
Former Dentist Address_____ City_____ State_____ Zip_____
Former Dentist Phone Number_____ How long since your last visited a Dentist_____
How often do you brush?_____ How often do you floss?_____
Have you ever adverse reaction to a local anesthetic? Yes ☐ No ☐
Have you had any serious trouble associated with previous dental treatment? Yes ☐ No ☐
If yes, What?_____
Do you use tobacco? Yes ☐ No ☐ If yes, what type? Cigarettes ☐ Cigar ☐ Pipe ☐ Chewing ☐
Does dental treatment make you nervous? No ☐ Slightly ☐ Moderately ☐ Extremely ☐

Check all that apply:

☐ Bad Breath
☐ Bleeding gums/ Swollen gums
☐ Clicking or popping jaw
☐Food collecting between teeth
☐ Grinding Teeth
☐ Loose teeth or broken fillings
☐ Orthodontic Treatment
☐ Pain around ear
☐ Sensitivity to cold
☐ Sensitivity to hot
☐ Sensitivity to sweets
☐ Sensitivity when biting
☐ Sores/ growths in your mouth

Medical History

Physicians Name_____ Phone #_____
Physicians Address_____ City_____ Zip_____
Are you in good health? Yes ☐ No ☐
Date of your last physical examination? _____ Any current treatments?_____
Have you had a serious illness or operation? Yes ☐ No ☐ If yes, what?_____
Have you been hospitalized in the past 5 years? If yes, why? _____
Have you had a blood transfusion? Yes ☐ No ☐ If yes, give approximate dates?_____
Have you taken any group of drugs referred to as "fen-phen"? These include combinations of Lonimin, Adipex, Fastin (Phentermine brands), Pondimin (fenfluramine) and redux (defenfluramine). Yes ☐ No ☐
Women, are you pregnant? Yes ☐ No ☐ Nursing? Yes ☐ No ☐ Taking birth control pills? Yes ☐ No ☐

Check if you have any of the following? Check all that apply:

☐Anemia	☐Cough, Persistent	☐High Blood Pressure	☐Respiratory Disease	☐Tuberculosis
☐Arthritis, Rheumatism	☐Cough up Blood	☐HIV/AIDS	☐Rheumatic Fever	☐Tumor or
☐Artificial Heart Valves	☐Diabetes	☐Hormone Therapy	☐Scarlet Fever	growth on head
☐Asthma	☐Epilepsy	☐Jaw Pain	☐Shortness of Breath	☐Ulcer
☐Back Problems	☐Fainting	☐Jaundice	☐Sinus Trouble	☐Veneral Disease
☐Blood Disease	☐Glaucoma	☐Kidney Disease	☐Skin Rash	
☐Cancer	☐Headaches	☐Liver Disease	☐Stroke	
☐Chemotherapy	☐Heart Problems	☐Mitral Valve Prolapse	☐Swelling of Feet	
☐Circulatory Problems	☐Hemophilia	☐Pacemaker	☐Swollen Neck Glands	
☐Cortisone Treatments	☐Hepatitis: Type__	☐Psychiatric Care	☐Thyroid Problems	
		☐Radiation Treatment	☐Tonsilitis	

Medications

List any medications you are currently taking and the correlating diagnosis:

_____
_____
Pharmacy name_____
Phone_____

Allergies

☐ Aspirin ☐ Barbiturates (Sleeping Pills) ☐ Codeine ☐ Iodine ☐ Latex ☐ Local Anesthetic
☐ Penicillin ☐ Sulfa ☐ Other_____

ASSIGNMENT & RELEASE & SIGNATURE

I Certify that I, & my dependent(s), have insurance coverage with _____ and
Name of Insurance Company
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. To the best of my knowledge the Medical History information is complete and correct.

_____ _____ _____
Signature of Patient, Parent, Guardian, Personal Representative Date Relationship to Patient