NAME _____ DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMAIL _____ CELL PHONE _____ HOME PHONE _____

Would you like to receive correspondence via email? ☐YES ☐NO Would you like to receive correspondence via text? ☐YES ☐NO

DRIVER'S LICENSE # _____ STATE OF ISSUE _____

☐MALE ☐FEMALE

SS# _____ BIRTHDATE _____

CHECK APPROPRIATE BOX ☐MINOR ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED ☐SEPARATED

IF COLLEGE STUDENT, FT/PT, NAME OF SCHOOL _____ CITY _____ STATE _____

PATIENT OR PARENT'S EMPLOYER _____ WORK PHONE _____

SPOUSE OR PARENT'S NAME _____ EMPLOYER _____ WORK PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

DRIVER'S LICENSE# _____ BIRTHDATE _____ SS# _____

EMPLOYER _____ WORK PHONE _____

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS# _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

INSURANCE COMPANY _____ TELEPHONE # _____

POLICY # _____ GROUP # _____

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

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS# _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

INSURANCE COMPANY _____ TELEPHONE # _____

POLICY # _____ GROUP # _____

I certify that I, and/or my dependent(s) have insurance coverage and assign directly to this dental office 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.

X _____ _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN, IF MINOR **DATE**

Dental History

What would you like to do today?_____ Are you in dental discomfort today?_____

Former Dentist_____ Phone Number_____

Address, City, State_____

Date of last dental care_____ Date of last X-rays_____

Y N Bad breath Y N Food collection between teeth Y N Sensitivity to cold Y N Sore or growth in mouth

Y N Bleeding gums Y N Grinding or clenching teeth Y N Sensitivity to sweets

Y N Periodontal treatment Y N Clicking or popping jaw Y N Sensitivity when biting

How often do you brush?_____ Floss?_____

How do you feel about your teeth?_____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Y N

Other information about your dental health or previous treatments_____

Medical History

Physician's name_____Phone_____

Date of last visit _____ Have you had any serious illness or operations? Y N

If Yes, describe_____

Are you currently under a physicians care? Y N If Yes, describe_____

Have you ever had a blood transfusion? Y N If Yes, give approximate dates_____

Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Circle Yes or No whether you have had any of the following:

Y N AIDS/HIV Positive
Y N Anaphylaxis
Y N Anemia
Y N Arthritis, Rheumatism
Y N Artificial heart valves
Y N Artificial joints
Y N Asthma
Y N Atopic (allergy prone)
Y N Back problems
Y N Blood disease
Y N Cancer
Y N Chemical dependency
Y N Chemotherapy
Y N Circulatory problems
Y N Cortisone treatments

Y N Cough, persistent
Y N Cough up blood
Y N Diabetes
Y N Epilepsy
Y N Fainting
Y N Food allergies
Y N Glaucoma
Y N Headaches
Y N Heart murmur
Y N Heart problems
describe_____
Y N Hemophilia or abnormal bleeding
Y N Herpes
Y N Hepatitis
Y N High blood pressure

Y N Jaw pain
Y N Kidney disease or malfunction
Y N Liver disease
Y N Material allergies
Y N Allergies to latex, metals or chemicals
Y N Mitral valve prolapse
Y N Nervous problems
Y N Pacemaker/ heart surgery
Y N Psychiatric care
Y N Rapid wt gain or loss
Y N Radiation treatment
Y N Respiratory disease
Y N Rheumatic/Scarlet fever

Y N Shingles
Y N Shortness of breath
Y N Skin rash
Y N Spina Bifida
Y N Stroke
Y N Surgical implant
Y N Swelling of feet or ankles
Y N Thyroid disease or malfunction
Y N Tobacco habit
Y N Tonsillitis
Y N Tuberculosis
Y N Ulcer/Colitis
Y N Venereal disease

Is patient currently taking any medications? If Yes, List all:

_____

_____

Does patient have any drug allergies? If Yes, List all:

_____

_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist and his staff to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist and his staff.

I authorize the insurance company indicated to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist and his staff to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____Date_____

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