WELCOME

We are pleased to welcome you to our practice. If you have questions, we'll be glad to help you.
We look foward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name *First Name* *Preferred Name*

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ **Email** _____

Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by _____ Occupation _____

How did you hear about us? ❑ Google ❑ Yelp ❑ Website ❑ Facebook ❑ Flyer ❑ Family/Friend _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name *First Name* *Preferred Name*

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Employer _____ Insurance Company _____

Phone _____ Contract # _____ Group # _____ Subscriber # _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Subscriber Employed By _____

Contract # _____ Group # _____ Subscriber # _____

I acknowledge that today I have received a copy of the Notice of Privacy Practice. I give permission to release treatment and financial information to the person(s) named concerning my account _____

Signature _____

PLEASE COMPLETE BOTH SIDES

DENTAL HISTORY

What brings you in? _____ Are you in dental discomfort today? ❑ Yes ❑ No

Date of last dental care _____

Check (✓) if you have had problems with any of the following:

❑ Bad Breath
❑ Bleeding Gums/Gum Disease
❑ Clicking/Popping Jaw
❑ Food Collection Between Teeth
❑ Grinding/Clenching Teeth
❑ Loose Teeth/Broken Fillings
❑ Migraines/Headaches
❑ Sesitivity to Hot/Cold/Sweets
❑ Sores/Growths in Mouth

How often do you brush? _____ Floss ? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Yes ❑ No

Other information about your dental health or previous treatment: _____

I am interested in/would like more information about: ❑ Invisalign ❑ Implants ❑ Whitening ❑ Botox/Fillers ❑ Cosmetic Work

MEDICAL HISTORY

Physician's Name _____ Phone _____

Date of last visit _____ Have you had any serious illness or operations? ❑ Yes ❑ No

If yes, describe _____

Are you currently under physician care? ❑ Yes ❑ No If yes, describe _____

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ❑ Yes ❑ No

Women: Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No

Check (✓) if you have had any of the following:

❑ AIDS/HIV Positive
❑ Anaphylaxis/Allergy
Describe _____
❑ Anemia
❑ Anorexia/Bulimia
❑ Arthritis, Rheumatism
❑ Artificial Heart Valves/Joint/ Heart Murmer
❑ Asthma
❑ Bariatric Surgery
❑ Blood Disease/Hemophilia/ Abnormal Bleeding
❑ Chemical Dependency
❑ Cancer/Chemo/Radiation
❑ Diabetes
❑ Epilepsy
❑ Fainting/Head Injury
❑ High BP/Heart Issues
❑ Herpes
❑ Hepatitis/Liver
❑ Kidney Disease
❑ Nervous Problems
❑ Stroke
❑ Tobacco Habit
Describe _____
❑ Pacemaker
❑ Ulcers/Stomach Issues
❑ Other
Describe _____

Medications? If yes, list all:

_____

_____

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 to help determine appropriate and healthful dental treatment. If there is any change in medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay 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 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.

I acknowledge/agree to the Deposit of $100.00 for the Specialist Appointments. $50.00 is the regular Deposit due.

Payment is due in full at the time of treatment.

Signature _____ Date _____