

# Welcome

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

## About You

Today's Date \_\_\_\_\_ E-mail Address \_\_\_\_\_

Referred by \_\_\_\_\_

**Name:** \_\_\_\_\_ I prefer to be called \_\_\_\_\_  
Last first MI

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Social Security # \_\_\_\_\_  Single  Married  Divorced  
 Male  Female  Widowed  Separated  
Drivers License # \_\_\_\_\_

**Home Address:** \_\_\_\_\_  
Street City State Zip

Home Ph. # (\_\_\_\_) \_\_\_\_\_ Pager /Car # (\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_

Where and when are the best times to reach you? \_\_\_\_\_

**Employer:** \_\_\_\_\_ How long there? \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's address \_\_\_\_\_  
Street/PO Box City State Zip

## Neighbor or Relative not living with you

His/Her Name \_\_\_\_\_ Relation \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_ Home # (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

## Spouse or Parent Information

His/Her Name: \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_\_

Employer: \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Drivers Lic. \_\_\_\_\_

## Insurance Information

Primary Insurance \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Group (Policy) # \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Insured's Name: \_\_\_\_\_ S.S. # \_\_\_\_\_ Insured Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Relation \_\_\_\_\_

Insured Employer \_\_\_\_\_ Employers Address \_\_\_\_\_  
Street City State Zip

Secondary Insurance \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_ Group (Policy) # \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Insured's Name: \_\_\_\_\_ S.S. # \_\_\_\_\_ Insured Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Relation \_\_\_\_\_

Insured Employer \_\_\_\_\_ Employers Address \_\_\_\_\_  
Street City State Zip

CIRCLE ONE

- 1. Are you having pain or discomfort at this time?.....YES NO
- 2. Do you feel very nervous about having dental treatment?.....YES NO
- 3. Have you ever had a bad experience in the dental office?.....YES NO
- 4. Have you been a patient in the hospital during the past two years?.....YES NO
- 5. Have you been under the care of a medical doctor during the past two years?.....YES NO

Physician's Name \_\_\_\_\_ Phone # \_\_\_\_\_  
 Address \_\_\_\_\_

- 6. Have you taken any medicine or drugs during the past two years?.....YES NO
- 7. Are you now taking any medication, drugs or pills?.....YES NO  
 If yes, please list: \_\_\_\_\_
- 8. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance.....YES NO  
 If yes, please list: \_\_\_\_\_

9. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

|                               |                                  |                                 |
|-------------------------------|----------------------------------|---------------------------------|
| YES NO Heart Failure          | YES NO Emphysema                 | YES NO Hepatitis A (infectious) |
| YES NO Heart Disease          | YES NO Cough                     | YES NO Hepatitis B (serum)      |
| YES NO Angina Pectoris        | YES NO Tuberculosis (TB)         | YES NO Liver Disease            |
| YES NO High Blood Pressure    | YES NO Asthma                    | YES NO Yellow Jaundice          |
| YES NO Heart Murmur           | YES NO Hay Fever                 | YES NO Blood Transfusion        |
| YES NO Rheumatic Fever        | YES NO Sinus Trouble             | YES NO Drug Addiction           |
| YES NO Mitral Valve Prolapse  | YES NO Allergies or Hives        | YES NO Hemophilia               |
| YES NO Scarlet Fever          | YES NO Diabetes                  | YES NO Venereal Disease         |
| YES NO Artificial Heart Valve | YES NO Thyroid Disease           | (Syphilis, Gonorrhea)           |
| YES NO Heart Pacemaker        | YES NO X-Ray or Cobalt treatment | YES NO Cold sores               |
| YES NO Heart Surgery          | YES NO Chemotherapy              | YES NO Fever Blisters           |
| YES NO Artificial Joints      | YES NO Arthritis                 | YES NO Epilepsy or Seizures     |
| YES NO Anemia                 | YES NO Rheumatism                | YES NO Fainting or dizzy spells |
| YES NO Stroke                 | YES NO Cortisone Medicine        | YES NO Nervousness              |
| YES NO Kidney Trouble         | YES NO Glaucoma                  | YES NO Psychiatric Treatment    |
| YES NO Ulcers                 | YES NO Pain in Jaw Joints        | YES NO Sickle Cell Disease      |
| YES NO Cosmetic Surgery       | YES NO HIV+                      | YES NO Bruise Easily            |

- 10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? YES NO
- 11. Do your ankles swell during the day? YES NO
- 12. Do you use more than 2 pillows to sleep? YES NO
- 13. Have you lost or gained more than 10 pounds in the past year? YES NO
- 14. Do you ever wake up from sleep short of breath? YES NO
- 15. Are you on a special diet? YES NO
- 16. Has your medical doctor ever said you have a cancer tumor? YES NO
- 17. Do you have any disease, condition, or problem not listed? YES NO

FOR WOMEN ONLY:

Are you pregnant?  Yes  No If yes, what month? \_\_\_\_\_ Are you taking birth control pills?  Yes  No

I understand the above information is necessary to provide me with dental care in safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) \_\_\_\_\_ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made, and that fees may be assessed for missed appointments without 24 hours notice.. I further understand that a finance charge (18% annually) will be added to any balance over 60 days in the event of default I(We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient \_\_\_\_\_ Date \_\_\_\_\_

Parent or Responsible Party \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_

