

Welcome to Our Practice

Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you and maintaining your dental health.

Date _____ Home Phone _____

Name _____ Soc. Sec. # _____

Address _____

City _____ State _____ Zip _____ TDL# _____

Sex " M " F Age _____ Birthdate _____ " Single " Married

Cell or pager number _____

Patient Employed by _____

Occupation _____ Phone # _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____

Relationship _____ Phone _____

Person Responsible for Account _____

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

Employed by _____ Work # _____

We will file your insurance for you. All deductible and patient portions are due and payable at the time of your visit. The remaining portion will be billed to you upon receipt of the insurance payment and payable within 30 days. You are responsible for the remaining balance after your insurance pays. Be advised that any delinquent balance of 120 days or more will be subject to a collection fee of 40% of the existing balance.

Signature

Date

CURRENT MEDICATIONS _____

ALLERGIES _____

Please check the following:

- | | | | | | | | | |
|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|------------------------|
| Y | N | | Y | N | | Y | N | |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis, Rheumatism | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Heart Valves | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Scarlet Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Joints | <input type="checkbox"/> | <input type="checkbox"/> | Headaches | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | Sinus trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | Back Problems | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Steroid Treatment |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Disease | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis, Type ____ | <input type="checkbox"/> | <input type="checkbox"/> | Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemical Dependency | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Swelling of feet/ankle |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> | HIV | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Circulatory Problems | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital Heart Defect | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> | Ulcer |
| <input type="checkbox"/> | <input type="checkbox"/> | Cough, Persistent | <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Care | <input type="checkbox"/> | <input type="checkbox"/> | Weight Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Diet Medications | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Treatment | <input type="checkbox"/> | <input type="checkbox"/> | Other |

(Women)

Pregnant? €Yes €No Nursing? €Yes €No Taking birth Control? €Yes €No

Reason for today's visit _____

Former Dentist _____ City, State _____

Date of last dental visit _____ Date of last X-rays _____ Date of Last Cleaning _____

Please check the following:

DENTAL HISTORY

- | | | | | | | | | |
|--------------------------|--------------------------|-------------------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|-------------------------|
| Y | N | | Y | N | | Y | N | |
| <input type="checkbox"/> | <input type="checkbox"/> | Bad breath | <input type="checkbox"/> | <input type="checkbox"/> | Gums swollen/tender | <input type="checkbox"/> | <input type="checkbox"/> | Sensitivity to cold |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding gums | <input type="checkbox"/> | <input type="checkbox"/> | Jaw pain/tiredness | <input type="checkbox"/> | <input type="checkbox"/> | Sensitivity to heat |
| <input type="checkbox"/> | <input type="checkbox"/> | Blisters of lips or mouth | <input type="checkbox"/> | <input type="checkbox"/> | Lip or cheek biting | <input type="checkbox"/> | <input type="checkbox"/> | Sensitivity to sweets |
| <input type="checkbox"/> | <input type="checkbox"/> | Burning sensation on tongue | <input type="checkbox"/> | <input type="checkbox"/> | Loose teeth | <input type="checkbox"/> | <input type="checkbox"/> | Sensitivity when biting |
| <input type="checkbox"/> | <input type="checkbox"/> | Chew on one side of mouth | <input type="checkbox"/> | <input type="checkbox"/> | Broken fillings | <input type="checkbox"/> | <input type="checkbox"/> | Sores/growth in mouth |
| <input type="checkbox"/> | <input type="checkbox"/> | Smoke/chew tobacco | <input type="checkbox"/> | <input type="checkbox"/> | Mouth pain | | | How often do you brush? |
| <input type="checkbox"/> | <input type="checkbox"/> | Dry mouth | <input type="checkbox"/> | <input type="checkbox"/> | Orthodontic treatment | | | How often do you floss? |
| <input type="checkbox"/> | <input type="checkbox"/> | Fingernail biting | <input type="checkbox"/> | <input type="checkbox"/> | Pain around ear | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Food collection between teeth | <input type="checkbox"/> | <input type="checkbox"/> | Periodontal treatment | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Grinding teeth | <input type="checkbox"/> | <input type="checkbox"/> | | | | |

Is there anything you would like to change about your smile? Y/N____ What?_____

All of the above information is accurate to the best of my knowledge.

I authorize my insurance company to pay the dentist or dental group 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.

Signature

Date