Welcome!

Thank you for selecting our dental healthcare team! Our commitment is to provide you with the highest quality care, personalized attention, and a positive experience with each visit. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions, please ask us – we will be happy to help!

Patient Information *(CONFIDENTIAL)*

Last Name__________________________ First_________________________ MI______ Nickname____________________

Address____ City_________________________ State_____ Zip_________

Date of Birth_________________________ Soc. Sec. #___________________ Gender_______ Family Status______________

Home phone_______________________________________ Work Phone____

Cellular Phone_____________________________________ e-mail address______________________________________

Person to contact for emergencies____ Phone______________________

How did you hear about us? ____

Responsible Party *(if other than self)*

Name____ Relationship to patient___________________

Address____ City_________________________ State_____ Zip_________

Home phone____ Soc. Sec. #___________________ Date of Birth___________

Dental Insurance Information *(if applicable)*

Name of insured____ is insured a patient? ____________________

Insured's Date of Birth________________ Social Security #_________________ Relationship to patient___________________

Insured's Employer Name____

Address____ City_________________________ State_____ Zip_________

Ins. Plan Name____ Group #_________________________

Ins. Plan Address______________________________________ City__________________________ State_____ Zip_________

DO YOU HAVE SECONDARY DENTAL INSURANCE? YES____ NO_____ IF YES, COMPLETE THE FOLLOWING:

Name of insured____ is insured a patient? _____________________

Insured's Date of Birth________________ Social Security #_________________ Relationship to patient____________________

Insured's Employer Name____

Address____ City_________________________ State_____ Zip_________

Ins. Plan Name____ Group #_________________________

Ins. Plan Address______________________________________ City__________________________ State_____ Zip_________

Patient Dental History

When was your last dental visit? __________________________ What was done at that time? ___________________________

Are you currently experiencing any specific problems? ____

Do your gums bleed while brushing or flossing? ____

Have you experienced any problems in your jaw? ____

(please continue on reverse)

Have you had orthodontic treatment? ____

Have you had any unusual effects from previous dental treatment? ____

Do you require pre-medication or antibiotics prior to dental treatment? ______ If yes, please explain: ________________________

____

If there were one thing you could change about your smile, what would it be? ______________________________________

____

What have you liked about previous visits to the dentist? ____

____

What is one thing you do not like about visiting the dentist? ____

Patient Medical History

Physician____ Phone______________________ Date of last Physical_____________

Are you taking any medications?_______ If yes, please complete below:

Drug_____________ Dose_________ Reason___________ Drug_____________ Dose_________ Reason___________

Drug_____________ Dose_________ Reason___________ Drug_____________ Dose_________ Reason___________

Drug_____________ Dose_________ Reason___________ Drug_____________ Dose_________ Reason___________

Drug_____________ Dose_________ Reason___________ Drug_____________ Dose_________ Reason___________

Are you allergic to local anesthetics or any medications used in the dental office? ___________________________________

Please list____

Have you been hospitalized in the last 5 years?_______ Why?____

Do you consume alcoholic beverages?_______ Smoke tobacco?_______ Use recreational drugs?__________________________

Women: Might you be pregnant? YES_____ NO_____

Are you nursing? YES_____ NO_____

Are you taking birth control pills? YES_____ NO_____

Do you have or have you had any of the following? (Please circle)

AIDS	Glaucoma	Kidney Disease	Stomach Problems
Allergies	Growths	Low Blood Pressure	Stroke
Anemia	Hay Fever	Liver Disease	Tuberculosis
Arthritis	Head Injuries	Mental Disorders	Tumors
Blood Disease	Heart Disease/Problems	Nervous Disorders	Ulcers
Cancer	Headaches	Penicillin Allergy	Venereal Disease
Cholesterol	Head Injury	Pacemaker/Other	OTHER:
Codeine Allergy	Heart Murmur	Radiation Treatment	________________
Diabetes	Hepatitis	Respiratory Problems	________________
Dizziness	High Blood Pressure	Rheumatic Fever	________________
Epilepsy	Jaundice	Rheumatism	________________
Fainting	Joint Replacements	Sinus Problems	

The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my or my dependent's health.

I authorize release of any information concerning my (or my dependent's) health care, advise and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to the dentist otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that the patient portion is due at time of service.

*Signature of Patient*____ *Date*_______________________

(Parent/Guardian if patient is a minor)