

Welcome

Thank you for selecting our dental healthcare team! We strive to provide you with excellent dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Personal Information

Date _____

Name (incl. middle init.) _____ Prefer to be called _____

Age ____ Birthday _____ Social Security # _____ Home Phone _____

Mailing Address _____ Work Phone _____

City _____ State ____ Zip _____ Cell Phone _____

Email Address _____

Sex M F Single Married Widowed Separated Divorced

Employer _____ Address _____

Spouse or Parents Name _____ Spouse or Parents Employer _____

In an emergency, we should contact _____ Home _____ Work _____

Whom may we thank for your referral? _____

Responsible Party

Relationship to Patient _____

Name _____ Birthday _____ Social Security # _____

Address (if different) _____ Home Phone _____

City _____ State ____ Zip _____ Work Phone _____

Employer _____ Address _____

Insurance Co. Name _____ Insurance Co. Phone _____

Insurance Address _____ City _____ State ____ Zip _____

Group Name _____ Group # _____

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and records of any treatment/examination rendered to me or my child to third party payors and/or other health practitioners. I agree to assign benefits to the doctor, and to be responsible for payment of all services rendered, whether or not paid by insurance. If I do not pay the entire balance within 25 days of the monthly billing date, a charge of 1.5% will be assessed each month. I agree that a \$50 fee/hour may be charged for failure to keep my scheduled appointments. I agree to pay all collection costs and reasonable attorney fees incurred in collecting the balance.

Signature _____

Patient's name: _____ Date: _____

Medical Information

Physician's name: _____ Phone: _____

What medications are you taking?

1. _____ For what purpose? _____
2. _____ For what purpose? _____
3. _____ For what purpose? _____
4. _____ For what purpose? _____
5. _____ For what purpose? _____
6. _____ For what purpose? _____
7. _____ For what purpose? _____
8. _____ For what purpose? _____

Have you ever been treated for:

	Yes	No		Yes	No
Abnormal blood pressure...	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints.....	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Asthma or Hay Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Head or Neck Injury	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever experienced		
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged bleeding	<input type="checkbox"/>	<input type="checkbox"/>

Are you allergic to:	Yes	No
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Codeine	<input type="checkbox"/>	<input type="checkbox"/>
Local anesthetics	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>
Others? _____		

Women:	Yes	No
Possibility you could be pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking birth control pills	<input type="checkbox"/>	<input type="checkbox"/>

Medical Information update:		Initials:		
Date	Comments	Patient	Dentist	Hygienist
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____