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 1.0% 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 _____

Medical Information

Patient's name: _____ **Date:** _____

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?** _____

***Are you on an Aspirin therapy?** ☐ Yes ☐ No → Doctor prescribed? ☐ Yes ☐ No

Do you, or have you ever used tobacco in any form? ☐ **Yes** ☐ **No** _____

Do you, or have you ever used recreational drugs? ☐ **Yes** ☐ **No** _____

Have you ever been treated for?

	Yes	No
Abnormal blood pressure....	☐	☐
Anemia ……...	☐	☐
Arthritis ……..…….	☐	☐
Artificial Joints...……	☐	☐
Asthma ……...…...	☐	☐
Exercise induced asthma?	☐	☐
Hospitalized for asthma?	☐	☐
Cancer …Type_____	☐	☐
Diabetes …….	☐	☐
Epilepsy ……..……...	☐	☐
Emphysema ……	☐	☐
Hay Fever ……...…..…..	☐	☐
Head Injury ……..……..	☐	☐

Are you allergic to:	**Yes**	**No**
Penicillin …….	☐	☐
Codeine ……	☐	☐
Local anesthetics …….	☐	☐
Milk …….……	☐	☐
Latex ……	☐	☐

Others? _____

	Yes	No
Heart Murmur ……	☐	☐
Heart Disease…..…..…….…	☐	☐
Hepatitis ….Type_____	☐	☐
Jaundice …….....	☐	☐
Neck Injury ……	☐	☐
Pacemaker ….…….....	☐	☐
Rheumatic Fever...……..	☐	☐
Sinus Trouble …….……....	☐	☐
Stroke ……...……..	☐	☐
Tuberculosis ……..…..	☐	☐
Ulcers ….……..…..	☐	☐
Have you ever experienced Prolonged bleeding? ……..	☐	☐

Women:	**Yes**	**No**
Are you taking birth control pills?	☐	☐
Possibility you could be pregnant?	☐	☐

- Estimated due date? _____

Doctor Signature _____ Date_____

Medical Update:

Date	Comments	**Initials:** Patient	Dentist	Hygienist
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____