WELCOME TO OUR PRACTICE

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

Patient Information

Patient Name: _____ Male or Female Today's Date: _____

Social Security #: _____ Birth Date: _____

Phone #: Home _____ Cell _____ Work _____

Can we send text and or leave message on these numbers? _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ Employer _____

Marital Status: Single Married Divorced Widowed

Whom should we contact in case of Emergency? _____

Health Information

Date of Last Dental Visit: _____ Reason for your visit today_____

Have you ever had any of the following? Please circle those that apply:

Aids	Drug Addiction	HIV	Scarlet Fever
Allergies (Seasonal)	Emphysema	Jaundice (current)	Seizures
Anemia	Epilepsy	Kidney Disease	Sinus Problems
Angina (chest pain)	Excessive Bleeding	Leukemia	Stomach Problems
Arthritis	Glaucoma	Liver Disease	Stroke
Artificial Joints	Hay Fever	Low Blood Pressure	Thyroid Disease
Asthma	Head Injuries	Mental Disorder	Tuberculosis
Blood Disease	Heart Disease	Nervousness/Depression	Tumors
Bruise Easily	Heart Lesions	Pacemaker	Ulcers
Cancer	Heart Murmur	Psychiatric Care	Venereal Disease
Chemotherapy	Heart Surgery	Pregnant (currently)	Other:
Cortisone Medication	Hepatitis A	Radiation Treatment	
Diabetes	Hepatitis B	Respiratory Problems	
Dialysis	Hepatitis C	Rheumatic Fever	
Dizziness/Fainting	High BP	Rheumatism	

Allergies

Amoxicillin	Erythromycin	Motrin	Valium
Penicillin	Ibupropfen	Nitrous Oxide	Other:
Codeine	Latex	Aspirin	None
Epinephrine	Lidocaine	Sulfa	

Women:

Are you Pregnant? Yes No Due Date? _____OBGYN #_____

Physician

Current Medications: _____

Primary Care Physician (medical doctor): _____ Ph#_____

Does your doctor suggest taking an antibiotic prior to dental procedure? _____

Are you currently taking blood thinner medication Yes No If so what_____

Pharmacy Name: _____ Ph# _____

Insurance Information

Dental Insurance Company: Primary _____

Name of Subscriber: _____ Date of birth _____ Subscriber ID# _____

Dental Insurance Company (Secondary): _____

Name of Subscriber: _____ Date of birth _____ Subscriber ID# _____

Whom may we thank for referring you to our practice? _____

Drive-By Yellow Pages Newspaper Mail Internet Insurance

Consent:

I have read, understand and agree to the terms and conditions. I authorize my insurance to pay my dental benefits directly to my dental office. The undersigned thereby authorizes the doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. 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 me or my dependents is mine, due and payable at the time of services rendered unless financial arrangements have been made.

Patient/Guardian Signature _____ **Date**_____

Responsible Party of Patient if under age of 18:

Parent/Guardian Name: _____DOB _____SSN#_____

Relationship to Patient: _____