



PATIENT INFORMATION

Date _____
 SS # _____
 Patient Name _____
Last Name

First Name Middle Initial
 Address _____
 City _____
 State _____ Zip _____
 E-mail _____
 Sex M F
 Birthdate _____
 Married Single Divorced
 Occupation _____
 Employer _____
 Employer Address _____
 Spouse's Name _____
 Birthdate _____
 SS # _____
 Spouse's Employer _____
 Whom may we thank for referring you? _____

DENTAL INSURANCE

Who is responsible for this account? _____
 Relationship to Patient _____
 Insurance Co. _____
 Group # _____
 Is patient covered by additional insurance? Yes No
 Subscriber's Name _____
 Birthdate _____ SS# _____
 Relationship to Patient _____
 Insurance Co. _____
 Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature

Date Relationship to Patient

PHONE NUMBERS

Home () _____ Work () _____ Ext _____ Cell Phone () _____
 Spouse's Work () _____ Best time and place to reach you _____
 IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)
 Name _____ Relationship _____
 Home () _____ Work Phone () _____

CREDIT CARD ON FILE

We will bill your insurance carrier for services provided and will accept assignment of benefits. **However, we will bill your credit card for any unpaid balances.**

Name of cardholder _____ Credit card number _____
 Expiration date _____ Billing zip code _____
 Signature _____

HEALTH HISTORY

Physician's Name _____ Phone # _____ Date of last visit _____

Place a mark on "yes" or "no" to indicate if you have had any of the following"

- | | | | | | |
|---|--|-----------------------|--|------------------------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or Growth on head
or neck | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally, with
extractions or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Congenital Heart Lesions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Fainting or dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Women:

- Are you pregnant? Yes No Due Date _____ Are you nursing? Yes No
- Taking birth control pills? Yes No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____

Phone () _____

ALLERGIES

- | | |
|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthesia |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Latex | _____ |

DENTAL HISTORY

Reason for today's visit _____

Do you snore? Yes No

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad Breath Yes No

Bleeding Gums Yes No

Chew on one side of mouth Yes No

Cigarette, pipe or cigar smoking Yes No

Clicking or popping jaw Yes No

Dry mouth Yes No

Food collection between teeth Yes No

Grinding teeth Yes No

Gums swollen or tender Yes No

Jaw pain or tiredness Yes No

Lip or cheek biting Yes No

Orthodontic treatment Yes No

Sensitivity to cold Yes No

Sensitivity to heat Yes No

Sensitivity to sweets Yes No

Sensitivity when biting Yes No

How often do you floss? _____

How often do you brush? _____