





We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

## **Patient Information**

Last Name   First Name   Initial    Additional Insurance   State   Zip   Home Phone    Last Name   Single   Married   Widowed   Separated   Divorced    Occupation   Susiness Phone    Business Address   Business Phone    Business Email    Whom may we thank for referring you?   Home Phone    Business Phone   Business Phone    Primary Insurance    Primary Insurance    Prist Name   Initial    Relation to Patient   Birthdate   Soc. Sec. #    Home Phone    City   State   Zip    Call Phone   Email    Person Responsible Employed by   Gocupation    State   Zip    Call Phone   Business Phone    Business Phone    Business Phone    Prist Name   Initial    Relation to Patient   Birthdate   Soc. Sec. #    Home Phone    City   State   Zip    Call Phone   Email    Person Responsible Employed by   Gocupation    Business Address   Business Phone    Business Phone    Susiness Email    Business Phone    Susiness Email    Business Phone    Susiness Email    Business Address   Business Phone    Susiness Email    Business Phone    Additional Insurance    Additional Insurance    Suspatient covered by additional insurance?   Yes   No	Name			Soc. Sec. #	
State   Zip   Home Phone	Last Name	First Name	Initial		
Call Phone	Address				
See _ M _ F Age Birthdate Single _ Married _ Widowed _ Separated _ Divorced _ Divorced _ Divorced _ Decupation _ Business Address Business Phone	City	State	Zip	Home Phone	
Patient Employed by Occupation  Business Address Business Phone  Business Phon	Cell Phone	Email			
Business Address susiness Entail  Whom may we thank for referring you?  Lell Phone   Business Phone    Person Responsible for Account   Last Name   First Name   Initial  Relation to Patient from patient)   Business Phone    Last Name   First Name   Initial  Relation to Patient   Birthdate   Soc. Sec. #    Laddress (if different from patient)   Birthdate   Birthdate    Last Name   Soc. Sec. #    Last Name   First Name   Initial  Relation to Patient   Home Phone    Lity   State   Zip    Last Name   Decorption    Email    Decorption   Soc. Sec. #    Last Name   State   Zip    Last Name   Birthdate    Relation to Patient   Soc. Sec. #    Additional Insurance Company   Phone    Subscriber #    Subscriber Name   Relation to Patient   Birthdate    Last Name   State   Zip   Home Phone    Last Name   Subscriber Name   Relation to Patient   Birthdate    Last Name   State   Zip   Home Phone    Last Name   State   Zip   Home Phone    Last Name   Soc. Sec. #    Last Name   State   Zip   Home Phone    Las	Sex D M D F Age Bir	thdate	□ Single □ M	arried 🗆 Widowed 🗅 Separated 🗅 Divo	rced
Business Email  Whom may we thank for referring you?  Notify in case of emergency	Patient Employed by			Occupation	
Whom may we thank for referring you?    Home Phone     Business Phone	Business Address		-	Business Phone	
Notify in case of emergency   Home Phone	Business Email				
Primary Insurance  Person Responsible for Account  Last Name  Prist Name  Last Name  First Name  Initial  Relation to Patient  Birthdate  Soc. Sec. #  Home Phone  Chell Phone  Person Responsible Employed by  State  Tap  Couract  Business Phone  Business Phone  Susiness Email  Insurance Company  Insurance Email  Contract #  Same of other dependents under this plan  Additional Insurance  Soc. Sec. #  Additional Insurance  Soc. Sec. #  Additional Insurance  Soc. Sec. #  Home Phone  Business Phone  Subscriber #  Subscriber #  Subscriber Fame  Soc. Sec. #  Home Phone  Business Phone  Soc. Sec. #  Soc.	Whom may we thank for referring you?				
Person Responsible for Account  Last Name  Birthdate Soc. Sec. #  Home Phone  Address (if different from patient)  Person Responsible Employed by State Susiness Address Susiness Email Sustance Company Susiness Email Sustance Company Susiness Email Sustance Company Susiness From  Additional Insurance  Suspective Name Relation to Patient Soc. Sec. #  Mittal  Mittal  Mittal  Mittal  Mittal  Relation to Patient Susiness Phone  Subscriber #  Subscriber #  Subscriber #  Subscriber Name Relation to Patient Soc. Sec. #  Jiny State Zip Home Phone  Email Soc. Sec. #  Jiny State Zip Home Phone Subscriber Rome Subscriber Employed by Subscriber Employed by Subscriber Flone Subscriber Name Relation to Patient Soc. Sec. #  Jiny State Zip Home Phone Subscriber Employed by Subscriber #					
Person Responsible for Account  Last Name  Birthdate Soc. Sec. # Home Phone  Address (if different from patient)  Enail  Person Responsible Employed by State Tip Coccupation Business Address Business Phone Business Email  Contract # Group # Subscriber #  Additional Insurance  so patient covered by additional insurance? Yes State Tip Coll Phone  Additional Insurance  Soc. Sec. #  Additional Insurance  Soc. Sec. #  Additional Insurance  Soc. Sec. #  Email  Soc. Sec. #  Additional Insurance  Soc. Sec. #  Email  Additional Insurance  Soc. Sec. #  Email  Birthdate  Additional Insurance  Soc. Sec. #  Email  Soc. Sec. #  Soc. Sec. #  Email  Soc. Sec. #  Soc. Sec. #  State Tip Home Phone  Subscriber Employed by  Business Phone  Soc. Sec. #  State Tip Home Phone  Soc. Sec. #  State Soc. Sec. #  State Soc. Sec. #  State Soc. Sec. #  State Soc. Sec. #  Soc. Sec. #  State Soc. Sec. #  Soc.	Cell Phone		Business Phone	e	
Person Responsible for Account    Last Name	Email	A A			
Relation to Patient Birthdate Soc. Sec. # Home Phone Sity State Zip Email Occupation Susiness Address (if different from patient) Susiness Phone Email Susiness Email Sontract # Soc. Sec. # Subscriber Final State State Subscriber Employed by State Subscriber Employed by State Subscriber Employed by State Subscriber Final Susiness Email Susiness Email Susiness Email Susiness Email Sustance Company Phone Subscriber # Subscriber # Subscriber # Subscriber # Subscriber Final Subscriber Name Relation to Patient Soc. Sec. # Subscriber Name Subscriber Final Subscriber Final Subscriber Final Subscriber Employed by State Zip Home Email Subscriber Employed by State Zip Home Phone Subscriber Employed by State Subscriber Employed by Subscriber Employed Business Phone Subscriber Employed Business Email Subscriber Employed Subscriber Empl		Prin	nary Insuranc	ce	
Relation to Patient Birthdate Soc. Sec. # Home Phone Sity State Zip Email Occupation Susiness Address (if different from patient) Susiness Phone Email Susiness Email Sontract # Soc. Sec. # Subscriber Final State State Subscriber Employed by State Subscriber Employed by State Subscriber Employed by State Subscriber Final Susiness Email Susiness Email Susiness Email Susiness Email Sustance Company Phone Subscriber # Subscriber # Subscriber # Subscriber # Subscriber Final Subscriber Name Relation to Patient Soc. Sec. # Subscriber Name Subscriber Final Subscriber Final Subscriber Final Subscriber Employed by State Zip Home Email Subscriber Employed by State Zip Home Phone Subscriber Employed by State Subscriber Employed by Subscriber Employed Business Phone Subscriber Employed Business Email Subscriber Employed Subscriber Empl	Person Responsible for Account				
Address (if different from patient)  State Zip				First Name	Initial
Address (if different from patient)  State Zip	Relation to Patient	Birthdate		Soc. Sec. #	
State Zip					
Email   Couract   Email					
Person Responsible Employed by	- 11 -1				
Business Phone Business Email Insurance Company Insurance Email Contract # Group # Subscriber #  Additional Insurance  Subscriber Manage of other dependents under this plan  Additional Insurance  Subscriber Manage Relation to Patient Birthdate  Address (if different from patient) Soc. Sec. #  State Zip Home Phone  Business Phone  Business Phone  Business Phone  Soc. Sec. #  Soc.					
Business Email Insurance Company Insurance Email Contract # Group # Subscriber #  Additional Insurance  Sepatient covered by additional insurance? Yes No Subscriber Name Relation to Patient Birthdate  Address (if different from patient) Soc. Sec. #  Sity State Zip Home Phone  Subscriber Employed by Business Email Insurance Company Phone  Soc. Sec. #  Subscriber Employed by Subscriber Employed Business Phone Subscriber Employed Business Email Subscriber Employed Business Phone Subscriber Employed Business Email Subscriber Employed Business Phone					
Insurance Company Phone					
Additional Insurance  Subscriber #  Additional Insurance  Subscriber #  Additional Insurance  Subscriber #  Subscriber #  Subscriber #  Subscriber #  Subscriber Name  Relation to Patient  Soc. Sec. #  Sity  State  Zip  Home Phone  Email  Subscriber Employed by  Business Phone  Susiness Email  Insurance Company  Phone  Subscriber #					
Contract # Group # Subscriber #				Thone	
Additional Insurance  s patient covered by additional insurance?				Cubaquiban #	
Additional Insurance  s patient covered by additional insurance?				Subscriber #	
Subscriber Name Relation to Patient Birthdate	Name of other dependents under this plan				
Subscriber Name		Addit	ional Insuran	ace	
Address (if different from patient)Soc. Sec. #	Is patient covered by additional insurance?	□ Yes □ No			
Address (if different from patient)Soc. Sec. #	Subscriber Name	Relation to Patient		Birthdate	
City					
Cell Phone         Email           Subscriber Employed by         Business Phone           Business Email         Phone           Insurance Company         Phone           Insurance Email         Subscriber #					
Business Phone					
Business Email   Phone   Pho					
Phone     Phone   Phone     Phone					
Insurance Email   Group #   Subscriber #				Phone	
Contract # Subscriber #				1 110110	
				Subscriber #	

Please complete both sides.

## **Dental History**

What would you like us to do today?		Are you in dental discomfort today	?				
Former Dentist	Address						
Dentist's Email Phone							
Date of last dental care Date of last x-rays							
Check ( ✓ ) yes or no if you have had problems with any of the following:							
	☐ Y ☐ N Food collection between teeth	☐ Y ☐ N Periodontal treatment	☐ Y ☐ N Sensitivity to sweets				
	$\square$ Y $\square$ N Grinding or clenching teeth	☐ Y ☐ N Sensitivity to cold	☐ Y ☐ N Sensitivity when biting				
☐ Y ☐ N Clicking or popping jaw	$\square$ Y $\square$ N Loose teeth or broken fillings	$\square$ Y $\square$ N Sensitivity to hot	$\square$ Y $\square$ N Sores or growths in mouth				
How often do you brush? Floss?							
How do you feel about the appearance of your teeth?							
	e reaction during or in conjunction wi	-	IY 🗆 N				
Other information about your dental health or previous treatment							
	Medica	al History					
Physician's name Phone							
Date of last visit	Have you had any serious il	lnesses or operations? 🔲 Y 🔲 N					
If yes, describe							
Are you currently under physician care?  \( \supersymbol{\text{Y}} \supersymbol{\text{N}} \) If yes, describe							
Have you ever had a blood transfusion? □ Y □ N If yes, give approximate dates							
Have you ever taken Fen-Phen/Redux? $\square$ Y $\square$ N							
Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. 🗖 Y 🗖 N							
Women: Are you pregnant? $\square$ Y $\square$ N   Nursing? $\square$ Y $\square$ N   Taking birth control pills? $\square$ Y $\square$ N							
Check ( $\checkmark$ ) yes or no whether you have	ve had any of the following:						
☐ Y ☐ N AIDS/HIV Positive	☐ Y ☐ N Cough, persistent	☐ Y ☐ N Jaw pain	☐ Y ☐ N Shingles				
☐ Y ☐ N Anaphylaxis	☐ Y ☐ N Cough up blood	☐ Y ☐ N Kidney disease or malfunction	☐ Y ☐ N Shortness of breath				
☐ Y ☐ N Anemia ☐ Y ☐ N Arthritis, Rheumatism	☐ Y ☐ N Diabetes ☐ Y ☐ N Epilepsy	☐ Y ☐ N Liver disease	□ Y □ N Skin rash □ Y □ N Spina Bifida				
☐ Y ☐ N Artificial heart valves	☐ Y ☐ N Fainting	☐ Y ☐ N Material allergies	☐ Y ☐ N Stroke				
☐ Y ☐ N Artificial joints	☐ Y ☐ N Food allergies	(latex, wool, metal, chemicals)	☐ Y ☐ N Surgical implant				
□ Y □ N Asthma	□ Y □ N Glaucoma	☐ Y ☐ N Mitral valve prolapse	☐ Y ☐ N Swelling of feet				
☐ Y ☐ N Atopic (allergy prone)	☐ Y ☐ N Headaches	☐ Y ☐ N Nervous problems	or ankles				
☐ Y ☐ N Back problems ☐ Y ☐ N Blood disease	□ Y □ N Heart murmur	☐ Y ☐ N Pacemaker/	☐ Y ☐ N Thyroid disease or malfunction				
☐ Y ☐ N Blood disease ☐ Y ☐ N Cancer	☐ Y ☐ N Heart problems  Describe	Heart surgery	☐ Y ☐ N Tobacco habit				
☐ Y ☐ N Chemical dependency	☐ Y ☐ N Hemophilia/	- ☐ Y ☐ N Psychiatric care ☐ Y ☐ N Rapid weight gain or loss	☐ Y ☐ N Tonsillitis				
☐ Y ☐ N Chemotherapy	Abnormal bleeding	☐ Y ☐ N Radiation treatment	☐ Y ☐ N Tuberculosis				
☐ Y ☐ N Circulatory problems	☐ Y ☐ N Herpes ☐ Y ☐ N Hepatitis	☐ Y ☐ N Respiratory disease	☐ Y ☐ N Ulcer/Colitis				
☐ Y ☐ N Cortisone treatments	☐ Y ☐ N High blood pressure	☐ Y ☐ N Rheumatic/Scarlet fever	☐ Y ☐ N Venereal disease				
Is patient currently taking any medications? If yes, list all:  Does patient have drug allergies? If yes, list all:							
	t						
	Autho	prization					
I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist							
to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.							
I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.							
I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.							
Signature		Date	na a a sand				
3	Payment is due in full at time of treatment, unless prior arrangements have been approved.						