PATIENT INFORMATION Date _____

Name _____ S.S. # _____

Address _____ City _____

State/Zip Code _____ Sex: M F Date of Birth _____

Home Phone _____ Work Phone _____ Cell _____

Email Address _____

Person to contact in case of emergency _____
Emergency contact phone number _____ Cell _____
Whom may we thank for referring you? _____

PRIMARY DENTAL INSURANCE

Name of Insured _____ Relation to Patient _____

Insurance Company _____ Phone _____

Insurance Company Address _____

City/State/Zip Code _____

Insured Employer _____ Phone _____

Employer Address _____

City/State/Zip Code _____

Group Number _____ Employee S.S. # _____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor 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 company. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of patient or parent if minor Date

DENTAL HISTORY

Reason for today's visit _____ Date of last dental visit_____
Previous Dentist _____ Reason for leaving _____

Check if you have or have had any of the following:

__ Bad breath
__ Broken fillings
__ Dry mouth
__ Grinding teeth
__ Loose teeth
__ Periodontal treatment
__ Sensitivity to sweets
__ Bleeding gums
__ Clicking or popping jaw
__ Fingernail biting
__ Gums swollen or tender
__ Mouth breathing
__ Sensitivity to cold
__ Sensitivity when biting
__ Blisters on lips or mouth
__ Cigarette or pipe smoking
__ Food collection b/w teeth
__ Jaw pain
__ Orthodontic treatment
__ Sensitivity to hot
__ Sores or growths in mouth

How often do you brush? _____ How often do you floss? _____
How fearful are you of dental treatment? _____ On a scale of 1-10, 10 being the highest fear? ___

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____
Have you had any serious illness or operations? ___Yes ___No If yes, describe _____
Have you ever had a blood transfusion? ___Yes ___No Taking birth control pills? ___Yes ___No

Check if you have or have had any of the following:

__ AIDS/HIV
__ Artificial heart valve
__ Cancer
__ Cortisone treatments
__ Glaucoma
__ Hemophilia
__ Kidney disease
__ Radiation treatment
__ Shortness of breath
__ Tuberculosis
__ Anemia
__ Asthma
__ Chemical dependency
__ Diabetes
__ Headaches
__ Hepatitis
__ Liver disease
__ Pacemaker
__ Respiratory disease
__ Stroke
__ Ulcers
__ Arthritis
__ Back problems
__ Chemotherapy
__ Epilepsy
__ Heart murmur
__ High blood pressure
__ Low blood pressure
__ Persistent cough
__ Rheumatic fever
__ Thyroid problems
__ Venereal diseases
__ Artificial joint
__ Blood disease
__ Circulatory problems
__ Fainting
__ Heart problems
__ Jaundice
__ Mitral valve prolapse
__ Prosthesis/Pins/Rods
__ Scarlet fever
__ Tonsillitis
__ Herpes

MEDICATIONS:

List any medications you are currently taking

_____
_____
_____

ALLERGIES:

_____
_____
_____

AUTHORIZATION

I have read and answered the above questions to the best of my knowledge.

_____ _____
Signature of patient or parent if minor *Date*