



NEW PATIENT INFORMATION

Name _____ Birthdate ___/___/___ Social Security # ___-___-_____
Address _____ City _____ State ___ Zip _____
Home Phone (____) ____-____ Cell Phone (____) ____-____ Pager (____) ____-____
Check One: Minor Single Married Divorced Widowed Separated
Patient's or Parent's Employer: _____ Work Phone (____) ____-____
Business Address _____ City _____ State ___ Zip _____
Spouse or Parent's Name _____ Employer _____ Work Phone (____) ____-____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency _____ Phone (____) ____-____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relation to Patient _____
Driver's Lic # _____ Birthdate ___/___/___ Social Security # ___-___-_____
Address _____ City _____ State ___ Zip _____
Currently a Patient in our Office? Yes No Home Phone (____) ____-____
Employer _____ Work Phone (____) ____-____

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____
Birthdate ___/___/___ Social Security # ___-___-_____
Date Employed _____
Employer _____ Work Phone (____) ____-____
Employer Address _____ City _____ State ___ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Address _____ City _____ State ___ Zip _____

ADDITIONAL INFORMATION

Name of Insured _____ Relation to Patient _____
Birthdate ___/___/___ Social Security # ___-___-_____
Date Employed _____
Employer _____ Work Phone (____) ____-____
Employer Address _____ City _____ State ___ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Address _____ City _____ State ___ Zip _____

MEDICAL HISTORY

Physician's Name _____ Phone # (____) ____-____ Date of Last Visit ____/____/____

Have you had any serious illnesses or operations ? Yes No If yes, describe _____

Have you ever had a blood transfusion ? Yes No If yes, approximate dates _____

(Women) Are you pregnant? Yes No Due Date: _____ Nursing? Yes No Taking birth control Pills? Yes No

Check if you have had any of the following:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Allergies, hay fever sinusitis | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hepatitis Type _____ | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Herpes | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Arthritis, rheumatism | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Any Immune Deficiency | <input type="checkbox"/> Slow Healing Wounds |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cough, persistent or bloody | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes Type _____ | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swelling of Feet or Ankles | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Back problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Head or Neck Tumor |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Bleeding Abnormally | <input type="checkbox"/> Weight Loss (Unexplained) | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Shortness of Breath |
| with Extractions or Surgery | <input type="checkbox"/> Blood Disease / Clotting Disorders | | <input type="checkbox"/> Smoker/Tobacco Use |

List all medications you are currently taking: _____

List any allergies to medications: _____

DENTAL HISTORY

Reason for today's visit _____ Date of Last Dental Visit ____/____/____

General Dentist _____ Date of Last X-Rays ____/____/____

Check if you have had any of the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Fingernail Biting | <input type="checkbox"/> Mouth Breathing |
| <input type="checkbox"/> Food Collection Between Teeth | <input type="checkbox"/> Mouth Pain with Brushing | <input type="checkbox"/> Bleeding Gums |
| <input type="checkbox"/> Sensitivity to Cold, Hot, Sweets, or Biting | <input type="checkbox"/> Orthodontic Treatment | <input type="checkbox"/> Blisters on Lips or Mouth |
| <input type="checkbox"/> Teeth Grinding / Clenching | <input type="checkbox"/> Nitrous Oxide (Laughing Gas) | <input type="checkbox"/> Burning Sensation on Tongue |
| <input type="checkbox"/> Growths or Sore Spots in your Mouth | <input type="checkbox"/> Novacaine or other Local Anesthetic | <input type="checkbox"/> Chew on One Side of Mouth |
| <input type="checkbox"/> Gums Swollen or Tender | <input type="checkbox"/> Jaw Pain, Clicking, or Popping | <input type="checkbox"/> Dry Mouth |
| <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Clicking or Popping Jaw | <input type="checkbox"/> Lip or Cheek Biting |

How often do you floss? _____ How often do you brush? _____

Have you ever had an allergic reaction or allergic symptoms to Novocaine, local, or General Anesthesia? Yes No

AUTHORIZATION & RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize the doctor and his representatives to release all information necessary to assist in securing the payment of my dental benefits. I understand I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of this signature on all insurance forms.

Signature of Patient

____/____/____
Date

Signature of Doctor

____/____/____
Date