

Welcome

Thank you for selection our office for your dental care. To help us meet your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us. We will be happy to help.

Patient Information (CONFIDENTIAL)

Soc. Sec. # _____
Email _____
Date _____

Name _____ Birthdate _____ Home Ph. _____ Cell Ph. _____

Address _____ City _____ State _____ Zip _____

Check appropriate box: Minor Single Married Divorced Widows Separated

If student, name of school/college _____ City _____ State _____ Zip _____

Patient's or parent's employer _____ Work Phone _____

Business address _____ City _____ State _____ Zip _____

Spouse's or parent's name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party Same as above

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ Occupation _____

Employer _____ Work Phone _____ SSN _____

Is this person currently a patient in our office? Yes No

Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address or employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group _____ Policy/ID # _____

Ins. co. address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ADDITIONAL INSURANCE? YES NO

IF YES, COMPLETE THE FOLLOWING

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address or employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group _____ Policy/ID # _____

Ins. co. address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

over please

Patient Medical History

Physician _____ Office Phone _____ Date of last exam _____

New Patient: Name of previous dentist and location _____

- | | | |
|--|--------------------------|--------------------------|
| 1. Are you under medical treatment now? | yes | no |
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you been hospitalized for surgical operation or serious illness within the last 5 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please explain _____ | | |
| 3. Are you taking any medications including non-prescription medicine? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, what medications are you taking? _____ | | |
| 4. Do you use tobacco? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use controlled substances? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have or have you had any of the following? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | | | | | | | |
|-----------------------------|--------------------------|--------------------------|------------------------------------|--------------------------|--------------------------|------------------------------------|--------------------------|--------------------------|
| High blood pressure | yes | no | Heart disease | yes | no | Chest pains | yes | no |
| | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart attack | <input type="checkbox"/> | <input type="checkbox"/> | Cardiac pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Easily winded | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic fever | <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen ankles | <input type="checkbox"/> | <input type="checkbox"/> | Angina | <input type="checkbox"/> | <input type="checkbox"/> | Hay fever/allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting/seizures | <input type="checkbox"/> | <input type="checkbox"/> | Mitral valve prolapse | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Radiation therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| Low blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy/convulsions | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Recent weight loss | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Liver disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Joint replacement | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney diseases | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis/Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Drug therapy for weight loss | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS or HIV infection | <input type="checkbox"/> | <input type="checkbox"/> | Sexually transmitted disease | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Thyroid problem | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | |

Women: Are you pregnant? _____ Nursing? _____

7. Are you allergic to or have you had any reaction to the following?

- | | | | | | |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| Local anesthetics (e.g. novocaine) | yes | no | Iodine | yes | no |
| | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin or any other antibiotics | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa drugs | <input type="checkbox"/> | <input type="checkbox"/> | Any metals (e.g. nickel, mercury, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| Codeine | <input type="checkbox"/> | <input type="checkbox"/> | Latex rubber | <input type="checkbox"/> | <input type="checkbox"/> |
| Sedatives | <input type="checkbox"/> | <input type="checkbox"/> | Other | <input type="checkbox"/> | <input type="checkbox"/> |

Authorization and Release

I certify that I have read and understand the above information and have answered to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (or parent if minor) X _____

Health History Review

Signature _____	Date _____	Signature _____	Date _____
Signature _____	Date _____	Signature _____	Date _____
Signature _____	Date _____	Signature _____	Date _____