Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely.

PERSONAL INFORMATION

Patient Name: ______________________ Date: __________
LAST FIRST MIDDLE

SS#: ______________ DOB: ______________ Age: __________

☐ Married ☐ Single ☐ Other

Residence Address: ______________________
STREET CITY STATE ZIP

Cell Phone #: __________ Work #: __________ Home Phone #: __________

Email: __________ Employer: __________ Position: __________

Spouse's Name: ______________________ SS#: __________

DOB: __________ Cell Phone: __________ Work Phone: __________

In an emergency, who should we call? ______________ Relationship: __________

Cell Phone #: __________ Work #: __________ Home Phone #: __________

Name of your medical Doctor: ______________ Medical Doctor's Phone #: __________

Name of your last Dentist: ______________ Dentist's Phone #: __________

PRIMARY INSURANCE

Insurance Company: ______________________

Mailing address: ______________________
STREET CITY STATE ZIP

Policy #: __________ Grp #: __________ Insurance Phone #: __________

Insured's Name: __________ SS#: __________ DOB: __________

Insured's Employer: ______________ Employer's Phone #: __________

SECONDARY INSURANCE (if applicable)

Insurance Company: ______________________

Mailing address: ______________________
STREET CITY STATE ZIP

Policy #: __________ Grp #: __________ Insurance Phone #: __________

Insured's Name: __________ SS#: __________ DOB: __________

Insured's Employer: ______________ Employer's Phone #: __________

__________ *I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.*
INITIALS *I fully understand I am solely responsible for any balance not paid for by my insurance company.*

BECAUSE WE LIKE TO THANK OUR REFERRALS WITH A GIFT, PLEASE SHARE WITH US THE PATIENT'S NAME: ______________________

YOUR MEDICAL HISTORY

Are you under a physician's care at this time? ❒ YES ❒ NO
Have you ever been hospitalized or had a major operation? ❒ YES ❒ NO
If Yes, what type of operation?___
Have you ever had an injury to your head or neck? ❒ YES ❒ NO
Are you on a special diet? ❒ YES ❒ NO
Do you smoke? ❒ YES ❒ NO
Would you like to quit smoking? ❒ YES ❒ NO
Are you currently taking any medications, drugs, or pills? Please list below.

___

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO:
❒ YES ❒ NO Local Anesthetics?
❒ YES ❒ NO Codeine or other narcotics?
❒ YES ❒ NO Penicillin?
❒ YES ❒ NO Aspirin?
❒ YES ❒ NO Other?

PLEASE LIST DRUG ALLERGIES:
___ ___
___ ___

List all known allergies:___

HAVE YOU EVER BEEN INFORMED THAT YOU NEED TO BE PRE-MEDICATED BEFORE DENTAL PROCEDURES? ❒ YES ❒ NO

If Yes, why?___

Heart trouble/disease ❒ YES ❒ NO
Mitral Valve Prolapse ❒ YES ❒ NO
Artificial Heart Valve ❒ YES ❒ NO
Heart Murmur ❒ YES ❒ NO
Chest Pain ❒ YES ❒ NO
Heart Attack (Date)___ ❒ YES ❒ NO
Congestive Heart Disease ❒ YES ❒ NO
High Blood Pressure ❒ YES ❒ NO
Low Blood Pressure ❒ YES ❒ NO
Rheumatic Fever ❒ YES ❒ NO
Scarlet Fever ❒ YES ❒ NO
Excessive Bleeding ❒ YES ❒ NO
Shortness of Breath ❒ YES ❒ NO
Lung Disease ❒ YES ❒ NO
Frequent Cough ❒ YES ❒ NO
Latex Allergy ❒ YES ❒ NO

Hay Fever ❒ YES ❒ NO
Asthma ❒ YES ❒ NO
Emphysema ❒ YES ❒ NO
TB ❒ YES ❒ NO
Cancer ❒ YES ❒ NO
X-Ray Treatment ❒ YES ❒ NO
Chemotherapy ❒ YES ❒ NO
Digestive Tract Disease ❒ YES ❒ NO
Ulcers ❒ YES ❒ NO
Recent Weight Loss ❒ YES ❒ NO
Diabetes ❒ YES ❒ NO
Hypoglycemia ❒ YES ❒ NO
Liver Disease ❒ YES ❒ NO
Hepatitis A (infectious) ❒ YES ❒ NO
Hep B (serum)/Carrier? ❒ YES ❒ NO
Hep C ❒ YES ❒ NO

Kidney Carrier ❒ YES ❒ NO
Renal Disease ❒ YES ❒ NO
Thyroid Disease ❒ YES ❒ NO
Parathyroid Disease ❒ YES ❒ NO
Arthritis (Gout) ❒ YES ❒ NO
Artificial Joint/s ❒ YES ❒ NO
AIDS or HIV Positive ❒ YES ❒ NO
Herpes ❒ YES ❒ NO
Seizures ❒ YES ❒ NO
Stroke ❒ YES ❒ NO
Are you Scared? ❒ YES ❒ NO
Fainting or Dizzy ❒ YES ❒ NO
Alzheimer's Disease ❒ YES ❒ NO
Pregnant (trimester ___) ❒ YES ❒ NO
Other ❒ YES ❒ NO
Specify:___

AUTHORIZATION

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DENTAL OFFICE OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.
In the case of default I promise to pay the balance, any legal interest, and the cost of collections which include a reasonable attorney's fee on my account.
Late cancellations (less than 24-hours) and no shows will be charged a fee of $89.00.

To the best of my knowledge, all the above answers are correct. If there are any changes in my medical health, I will inform the dentist before my next appointment or before any treatment is started. I have read and agree to all the terms outlined on this form. ***PERSON SIGNING MUST BE 18 YEARS OR OLDER.***

Signed: ___ Date: ___

Print Name: ___

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