WELCOME

PATIENT INFORMATION

Date _____

Patient _____

Home Address _____

Mailing Address _____

_____
City State Zip

Sex: ☐ M ☐ F Age _____ Birthdate _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS# _____

Occupation

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____

Occupation _____

Spouse's Employer _____

Spouse's Employer Address _____

Spouse's Employer Phone _____

Whom may we thank for referring you? _____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

If yes, Insurance Co. _____

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____
Relationship Date

PHONE NUMBERS

Home _____ Work _____ Ext _____ Cell _____ Spouse's Work _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental x-rays _____

Place a mark on "Yes" or "No" to indicate if you have or had any of the following:

Bad Taste ☐ Yes ☐ No

Bad Breath	☐ Yes	☐ No	Lip or cheek biting	☐ Yes	☐ No
Bleeding Gums	☐ Yes	☐ No	Loose teeth or broken fillings	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Mouth pain, brushing	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
Cigarette, pipe or cigar smoking	☐ Yes	☐ No	Periodontal treatrnent	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
Dark teeth	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
Food collection between teeth	☐ Yes	☐ No	Sores or growths in your mouth	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No	Unsightly teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No	How often do you floss?		
Jaw pain or tiredness	☐ Yes	☐ No	How often do you brush?		

If you had a magic wand, what would you change about your teeth? _____

HEALTH HISTORY

Physican's Name: _____ Date of last visit: _____

Physician's Address: _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Prosthetic Replacement	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Type _____			Shortness of Breath	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
			High Blood Pressure	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	HIV Positive	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swelling of Feet or Ankles	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No			
Chemotherapy	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No			
			Pacemaker	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Women:			Venereal Disease	☐ Yes	☐ No
Drug use (illegal)	☐ Yes	☐ No	Are you pregnant?	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Due date_____					
Epilepsy	☐ Yes	☐ No	Are you nursing?	☐ Yes	☐ No			

MEDICATIONS

List medications you are currently taking: _____

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

(Causing swelling, rash, hives, itching, or difficulty breathing)

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other Drugs _____

☐ Latex _____

I CONSENT TO TREATMENT AS NECESSARY OR DESIRABLE TO THE CARE OF THE PATIENT FIRST NAMED ABOVE, INCLUDING BUT NOT LIMITED TO WHATEVER DRUGS, MEDICINE, PERFORMANCE OF OPERATIONS, AND CONDUCT OF LABORATORY, X-RAY, OR OTHER STUDIES THAT MAY BE USED BY THE ATTENDING DOCTOR OR QUALIFIED DESIGNATE. I ALSO ACKNOWLEDGE FULL RESPONSIBILITY FOR THE PAYMENT OF SUCH SERVICES AND AGREE TO PAY THEM IN FULL AT THE TIME OF SERVICE. I ACKNOWLEDGE THAT IT IS MY RESPONSIBILITY AND NOT AN INSURANCE COMPANY TO PAY FOR ANY OR ALL SERVICES. ANY OUTSTANDING BALANCE AFTER 30 DAYS MAY INCUR A FINANCE CHARGE OF 18% PER ANNUM OR 1-1/2% PER MONTH.

Signed _____ _____ _____

Patient, Parent, or Agent (Must by 18 years or older) | Doctor | Date

UPDATES (Every 6 months)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

TFD 4051C