

# 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 in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

## Patient Information (CONFIDENTIAL)

Soc. Sec. # \_\_\_\_\_  
Date \_\_\_\_\_  
Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Check Appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated  Male  Female  
If Student, Name of School / College \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  Full Time  Part Time  
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 \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Driver's License # \_\_\_\_\_ Birthdate \_\_\_\_\_ Financial Institution \_\_\_\_\_  
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 of 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 ANY 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 of 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

PLEASE CHECK IF YOU HAVE HAD OR HAVE ANY OF THE FOLLOWING:

- AIDS OR HIV INFECTION
- HEART MURMUR
- MITRAL VALVE PROLAPSE
- RHEUMATIC FEVER
- JOINT REPLACEMENT OR IMPLANT
- HEPATITIS TYPE \_\_\_\_\_ DATE \_\_\_\_\_
- LATEX RUBBER
- TUBERCULOSIS
- CARDIAC PACEMAKER
- HEART ATTACK DATE \_\_\_\_\_
- HEART DISEASE
- STROKE
- ANGINA
- HIGH BLOOD PRESSURE
- LOW BLOOD PRESSURE
- DIABETES
- LIVER DISEASE
- KIDNEY DISEASE
- EPILEPSY
- FAINTING
- ASTHMA
- RESPIRATORY PROBLEMS
- CANCER
- EMPHYSEMA
- LEUKEMIA
- MS
- RADIATION THERAPY
- ARTHRITIS
- STOMACH TROUBLES/ULCERS
- THYROID
- SEXUALLY TRANSMITTED DISEASE
- MONO
- ALCOHOLISM/DRUG DEPENDENCY
- A.D.D./A.D.H.D.

PLEASE CHECK IF YOU ARE ALLERGIC TO ANY OF THE FOLLOWING:

- LOCAL ANESTHETIC
- PENICILLIN
- OTHER ANTIBIOTICS \_\_\_\_\_
- ASPRIN
- CODEINE
- METALS
- OTHER (PLEASE LIST):

LIST MEDICATIONS YOU ARE TAKING, INCLUDING NONPRESCRIPTION:

DO YOU TAKE ANY BLOOD THINNERS?

DO YOU USE TOBACCO? \_\_\_\_\_

DATE OF LAST DENTAL EXAM \_\_\_\_\_

PREVIOUS DENTIST \_\_\_\_\_

MEDICAL DOCTOR \_\_\_\_\_

## Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. 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 during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X

\_\_\_\_\_  
Signature of patient (or parent if minor)