WELCOME

PATIENT INFORMATION

Patient _____ Date _____

Home Address _____

Mailing Address _____
City State Zip

Home Phone _____ Cell Phone _____

Sex: ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Patient SS # _____

Occupation _____

Employer _____

Employer's Address _____

Employer's 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's Signature

_____ _____
Relationship Date

MEDICAL HISTORY - Please "X" each box if the answer is "YES"

☐ AIDS
☐ Anemia
☐ Angina Pectoris
☐ Arthritis
☐ Artificial Heart Valve
☐ Artificial Joint
☐ Asthma
☐ Bleeding Gums
☐ Chemotherapy
☐ Chronic Sinus
☐ Diabetes
☐ Dry Mouth
☐ Epilepsy
☐ Excessive Bleeding when Injured
☐ Fever Blisters
☐ Heart Attack
☐ Heart Disease
☐ Heart Murmur
☐ Heart Pacemaker
☐ Heart Surgery
☐ Hepatitis
☐ Hip Implants
☐ HIV
☐ Immunological Disease
☐ Kidney Disease
☐ Knee Implants
☐ Liver Disease
☐ Low / High Blood Pressure
☐ Malignancies
☐ Migraines
☐ Neurological Disorder
☐ Organ Transplant
☐ Osteoporosis
☐ Other Lung Disease
☐ Radiation Treatment
☐ Rheumatic Fever
☐ Rheumatoid Arthritis
☐ Stroke
☐ Systemic Lupus Erythematosus
☐ Thyroid Problems

Is your general health good? ☐ Y ☐ N
Do you take Aspirin daily? ☐ Y ☐ N
Do you Bruise easily? ☐ Y ☐ N
Are you Pregnant? ☐ Y ☐ N
Do you use Tobacco? ☐ Y ☐ N

Is there a mouth sensitivity to:
☐ Cold ☐ Heat ☐ Sweets
☐ Biting ☐ Chewing ☐ Previous Injury

Are you Allergic to any of the following:
☐ Aspirin ☐ Latex ☐ Sulfa Drugs
☐ Codeine ☐ Local Anesthetics ☐ Other (Specify) _____
☐ Antibiotics ☐ Penicillin

Please list any medications you are currently taking:
_____ _____
_____ _____
_____ _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I authorize treatment of the person named above and agree to pay all fees and charges for such treatment.

Patient Signature: _____ Date: _____