

Welcome

*The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely.
The better we communicate, the better we can care for you.*

1. TELL US ABOUT YOU:

TODAY'S DATE: _____/_____/_____ SSN _____/_____/_____
NAME _____ MR. / MRS. / MS. BIRTHDATE _____
HOME ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: _____ CELL PHONE: _____ PAGER: _____
E-MAIL ADDRESS _____
EMPLOYER: _____ EMPLOYER'S ADDRESS: _____
OCCUPATION: _____ WORK #: _____ EXT: _____
WHOM MAY WE THANK FOR REFERRING YOU? _____
PERSON RESPONSIBLE FOR ACCOUNT: _____

2. SPOUSE INFORMATION:

HIS/HER NAME: _____ DOB: _____
EMPLOYER: _____ WORK #: _____ (EXT) _____ SSN _____
CELL PHONE _____ E-MAIL _____

3. DENTAL INSURANCE:

PRIMARY DENTAL INSURANCE: _____
INSURANCE CO. PHONE: _____ GROUP #: _____ EMPLOYER: _____
INSURED'S NAME _____ SSN: _____ RELATION TO PT: _____
INSURED'S BIRTHDATE: _____/_____/_____
SECONDARY DENTAL INSURANCE: _____
INSURANCE CO. PHONE: _____ GROUP #: _____ EMPLOYER: _____
INSURED'S NAME _____ SSN: _____ RELATION TO PT: _____
INSURED'S BIRTHDATE: _____/_____/_____
INSURED'S BIRTHDATE: _____/_____/_____

IN THE EVENT OF AN EMERGENCY, IS THERE SOMEONE WHO LIVES NEAR YOU THAT WE SHOULD CONTACT?

HIS/HER NAME: _____ ADDRESS: _____ PHONE: _____

4. MEDICAL HISTORY:

DO YOU HAVE A PERSONAL PHYSICIAN? YES / NO NAME: _____ PHONE: _____

HEALTH IS: GOOD / FAIR / POOR ARE YOU CURRENTLY UNDER PHYSICIANS CARE? YES / NO

EXPLAIN: _____

PLEASE LIST ALL PRESCRIPTION/OVER THE COUNTER DRUGS YOU ARE NOW TAKING: _____

****ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? (PLEASE CIRCLE):**

ASPIRIN / CODEINE / DENTAL ANESTHETICS / ERYTHROMYCIN / LATEX / PENICILLIN / TETRACYCLINE

SULFUR DRUGS / OTHER _____

ARE YOU USING ANY OF THE FOLLOWING: ANTIBIOTICS / BLOOD THINNERS / ASPIRIN / MOTRIN / ALEVE / IBUPROFEN

FOR WOMEN: ARE YOU TAKING BIRTH CONTROL PILLS? YES / NO PREGNANT? _____ # WEEKS _____ NURSING _____

**HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?
(PLEASE CIRCLE):**

ANEMIA / RADIATION TREATMENT / ARTIFICIAL BONES, JOINTS / ARTIFICIAL VALVES / ASTHMA / ARTHRITIS / CANCER /
CHEMOTHERAPY / BLOOD TRANSFUSIONS / CONGENITAL HEART DEFECT / DIABETES / TUBERCULOSIS / DIFFICULTY
BREATHING / DRUG, ALCOHOL ABUSE / EMPHYSEMA / GLAUCOMA / EPILEPSY / FAINTING SPELLS / FEVER BLISTERS /
HERPES / HEART ATTACK / STROKE / HEART MURMUR / HEART SURGERY / PACEMAKER / HEMOPHILIA / ABNORMAL
BLEEDING / HEPATITIS / HIGH, LOW BLOOD PRESSURE / HIV+, AIDS / KIDNEY PROBLEMS / MITRAL VALVE PROLAPSE /
PSYCHIATRIC PROBLEMS / RHEUMATIC, SCARLETT FEVER / FREQUENT HEADACHES / SHINGLES / SINUS PROBLEMS /

ULCERS, COLITIS / VENERAL DISEASE / HOSPITALIZATIONS _____

PLEASE LIST ANY SERIOUS MEDICAL CONDITION(S) THAT YOU HAVE EVER HAD: _____

I UNDERSTAND THAT THE INFORMATION THAT I HAVE GIVEN TODAY IS CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT THIS INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS. I AUTHORIZE THE DENTAL STAFF TO PERFORM ANY NECESSARY DENTAL SERVICES THAT I MAY NEED DURING DIAGNOSIS AND TREATMENT WITH MY INFORMED CONSENT. I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE THE RELEASE OF ANY INFORMATION RELATIVE TO THIS CLAIM. I HEREBY AUTHORIZE PAYMENT OF MY INSURANCE BENEFITS, OTHERWISE PAYABLE TO ME, TO THE DENTIST LISTED ON THIS FORM. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS. I UNDERSTAND I AM RESPONSIBLE FOR ANY UNPAID BALANCE ON MY ACCOUNT.

SIGNATURE DATE

SIGNATURE DATE

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY. IT WILL ENABLE US TO HELP YOU MORE EFFECTIVELY. IF YOU HAVE ANY QUESTIONS AT ANY TIME, PLEASE DO NOT HESITATE TO ASK. WE ARE HAPPY TO HELP.

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC AND THE ADA.