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

Is your general health good?	☐ Y ☐ N	Is there a mouth sensitivity to:		
Do you take Aspirin daily?	☐ Y ☐ N	☐ Cold	☐ Heat	☐ Sweets
Do you Bruise easily?	☐ Y ☐ N	☐ Biting	☐ Chewing	☐ Previous Injury
Are you Pregnant?	☐ Y ☐ N			
Do you use Tobacco?	☐ Y ☐ N			

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: _____