WELCOME
TO OUR PRACTICE

Southern West Virginia Health System

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

Patient Information

Date: _____ Social Security #: _____ Birthdate: _____

Name: _____ Home Phone: _____
Last Name First Name Initial

Address: _____ Cell Phone: _____

City: _____ State: _____ Zip: _____ E-mail: _____

Sex: ☐M ☐F Marital Status: ☐Minor ☐Single ☐Married ☐Long Term Partner ☐Divorced ☐Widowed ☐Separated

Employer: _____ Business Phone: _____

Business Address: _____ Occupation: _____

Who should we thank you referring you? _____

Emergency Contact: _____ Phone: _____

Primary Insurance

Person Responsible for Account: _____
Last Name First Name Initial

Relationship to Patient: _____ Birthdate: _____ Social Security #: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____

Responsible Party Emolyed By: _____ Business Phone: _____

Business Address: _____ Occupation: _____

Insurance Company: _____

Insurance Company Address: _____

Subscriber I.D. #: _____ Group #: _____

Additional Insurance

Insured Name: _____
Last Name First Name Initial

Relationship to Patient: _____ Birthdate: _____ Social Secruity #: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____

Insured Employed By: _____ Business Phone: _____

Insurance Company: _____

Insurance Company Address: _____

Subscriber I.D. #: _____ Group #: _____

Dental Information

Former Dentist: _____ Date of Last X-Rays: _____

City, State: _____ How Often Do You Floss? _____

Date of Last Dental Visit: _____ How Often Do You Brush? _____

Please check all that apply:

Bad Breath ☐	Loose Teeth or Broken Fillings ☐	Sensitivity to Sweets ☐
Bleeding Gums ☐	Orthodontic Treatment ☐	Sensitivity When Biting ☐
Blisters on Lips or Mouth ☐	Pain Around Ear ☐	Frequent Headaches ☐
Fingernail Biting ☐	Periodontal Treatment ☐	Jaw, Head or Neck Injuries ☐
Grinding Teeth ☐	Sensitivity to Cold ☐	Jaw Difficulty: Clicking and/or Pain ☐
Lip or Cheek Biting ☐	Sensitivity to Heat ☐	Tooth Pain ☐

Medical History

Provider's Name: _____ Date of Last Visit: _____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illnesses or operations?	☐	☐
3. Are you currently taking any medication?	☐	☐
Please describe: _____		
4. Do you smoke?	☐	☐
5. Do you use alcohol, cocaine, or other drugs?	☐	☐
6. Do you wear contact lenses?	☐	☐

7. Have you had any allergic reactions to the following:	Yes	No
Local Anesthetics (e.g. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐
8.(Women Only) Are You:		
Pregnant	☐	☐
Nursing	☐	☐
Taking birth control pills	☐	☐

Please Check all that apply:

AIDS ☐	Emphysema ☐	Pacemaker ☐
Anemia ☐	Epilepsy ☐	Psychiatric Care ☐
Arthritis, Rheumatism ☐	Fainting or Dizziness ☐	Radiation Treatment ☐
Artificial Heart Valves ☐	Glaucoma ☐	Respiratory Disease ☐
Artificial Joints ☐	Headaches ☐	Rheumatic Fever ☐
Asthma ☐	Heart Murmur ☐	Scarlet Fever ☐
Back Problems ☐	Heart Problems ☐	Shortness of Breath ☐
Bleeding abnormally with extractions or surgery ☐	Hepatitis-Type _____ ☐	Sinus Trouble ☐
	Herpes ☐	Skin Rash ☐
Blood disease ☐	High Blood Pressure ☐	Stroke ☐
Cancer ☐	HIV Positive ☐	Swelling of Feet/Ankles ☐
Chemical Dependency ☐	Jaundice ☐	Swollen Neck Glands ☐
Chemotherapy ☐	Jaw Pain ☐	Thyroid Problems ☐
Chronic Fatigue Syndrome ☐	Latex Sensitivity ☐	Tonsilitis ☐
Circulatory Problems ☐	Kidney Disease ☐	Tuberculosis ☐
Congenital Heart Lesions ☐	Liver Disease ☐	Tumor or growth on head/neck ☐
Cortisone Treatments ☐	Low Blood Pressure ☐	Ulcer ☐
Cough- persistent or bloody ☐	Mitral Valve Prolapse ☐	Venereal Disease ☐
Diabetes ☐	Nervous Problems ☐	☐

Assignment of Benefits Agreement

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsibly Party _____ Date _____