A close-up of a person

Description automatically generated

|  |
| --- |
| 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 |  | Yes | No |
| 1. Are you currently under medical treatment?...... |  |  | 7. Have you had any allergic reactions to the following: |  |  |
| 1. Have you ever had any serious illnesses or |  |  | Local Anesthetics (e.g. novocaine)……………………….. |  |  |
| operations?....................................................... |  |  | Penicillin or other Antibiotics……………………………….. |  |  |
| 1. Are you currently taking any medication?.......... |  |  | Sulfa Drugs………………………………………………………. |  |  |
| Please describe: |  |  | Barbiturates (sleeping pills)………………………………….. |  |  |
|  |  |  | Sedatives…………………………………………………………. |  |  |
|  |  |  | Iodine……………………………………………………………... |  |  |
| 1. Do you smoke?................................................. |  |  | Aspirin……………………………………………………………. |  |  |
| 1. Do you use alcohol, cocaine, or other drugs?.... |  |  | Other……………………………………………………………… |  |  |
| 1. Do you wear contact lenses?............................. |  |  | 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 |  | Hepatitis-Type …………………… |  | Sinus Trouble…………………………….. |  |
| with extractions or surgery …………… |  | 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