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| 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:

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| 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 #:

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| 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 #:

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| 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:

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| --- | --- | --- |
| 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…………………………………..… [ ]  |

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| Medical History |

Provider’s Name: Date of Last Visit:

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| --- | --- | --- | --- | --- | --- |
|  | 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……………………………………... | [ ]  | [ ]  |

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| 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…………………………. | [ ]  |  | [ ]  |

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| 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