Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name				Soc. Sec. #	
Last .	Name First Nam	ie	Initial		
Address					
City		State	Zip	Home Phone	
Cell Phone		Email			
Sex □ M □ F Age	Birthdate		☐ Single ☐ Married	□ Widowed □ Separated □ Divorced	
Patient Employed by				Occupation	
Business Address				Business Phone	
Business Email					
•	0				
Notify in case of emergency			Home Phone		
Cell Phone			Business Phone		
Email					
		Primar	Insurance		
Person Responsible for Acc	ount	· Manag		Einek Mann o	To tet al
	Last	Name		First Name	Initial
Relation to Patient		Birthdate		Soc. Sec. #	
Address (if different from p	atient)			Home Phone	
City			State	Zip	
Cell Phone				Email	
Person Responsible Employ	ed by			Occupation	
Business Address				Business Phone	
Business Email					
Insurance Company				Phone	
Insurance Address					
Contract #		Group #		Subscriber #	
Name of other dependents u	ınder this plan				
				Phone	
		Addition	al Insurance		
Is patient covered by addition	onal insurance? 🗆 Yes 🗅 No				
Subscriber Name	Relati	ion to Patient		Birthdate	
Address (if different from p	atient)		Soc. Se	ec. #	
City		State	Zip	Home Phone	
Cell Phone				Email	
Subscriber Employed by				Business Phone	
				Phone	
				Subscriber #	
	under this plan	_			
*	-				

Please complete both sides.

Dental History

Near would you like us to do today?		Denta	i ilistory							
Date of last stemal care	What would you like us to do today?		Are you in dental discomfort today?							
Date of last dental care	Former Dentist	Address								
Check (\(\ \)) yes or no if you have had problems with any of the following: \(\) \ \) Bad breath	Dentist's Email	Phone								
Check (\(\ \)) yes or no if you have had problems with any of the following: \(\) \ \) Bad breath	Date of last dental care									
Y N Bad breath Y N Food collection between teeth Y N Sensitivity to cold Y N Sensitivity to sweets Y N Sensitivity to bot Y N Sensit										
Y N Bleeding gums			☐ Y ☐ N Periodontal treatment	☐ Y ☐ N Sensitivity to sweets						
A N N N N N N N N N				•						
Do you wish your teeft were white? Y N Do you wish your teeft were white? Y N Do you wish your teeft were white? Y N Are you unhappy with any fillings, crowns or bridges? Y N They one were perferenced an afters reaction during or in conjunction with a medical or dental procedure? Y N Other information about your dental health or previous treatment	0.0									
Do you wish your teeft were white? Y N Do you wish your teeft were white? Y N Do you wish your teeft were white? Y N Are you unhappy with any fillings, crowns or bridges? Y N They one were perferenced an afters reaction during or in conjunction with a medical or dental procedure? Y N Other information about your dental health or previous treatment	How often do you brush?	Floss?								
Do you wish your teeth were white? Y N Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Y N	-									
Medical History Physician's name										
Physician's name	•									
Physician's name										
Physician's name	•									
Date of last visit	Dhysician's name		•							
Are you currently under physician care?	•									
Are you currently under physician care? Y N If yes, describe		·	*							
Do you sonore?										
Have you ever been diagnoses with sleep apnea?		e: di di ii yes, describe								
Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva.	•	een annea? DV DN If ves do vou	use a CPAP? DY DN							
Do you smoke or use other tobacco/smokeless products?										
Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N Check (/) yes or no whether you have had any of the following: Y N AIDS/HIV Positive Y N Cough, persistent Y N Jaw pain Y N Y N Anaphylaxis Y N Cough up blood Y N Xidney disease or Y N Shortness of breath Y N Anaphylaxis Y N Diabetes Y N Y N Arthritis, Rheumatism Y N Epilepsy Y N Y N Arthritis, Rheumatism Y N Epilepsy Y N Y N Artificial heart valves Y N Fainting Y N Y N Artificial points Y N Food allergies Y N Asthrna Y N Glaucoma Y N Mitral valve prolapse Y N Y N Asthrna Y N Headaches Y N Redaches Y N Swelling of feet Y N Blood disease Y N Heart murmur Y N Pacemaker/ Y N Chemical dependency Y N Heart problems Y N Rapid weight gain or loss Y N Chemical dependency Y N Hemophilia/ N Rapid weight gain or loss Y N Tobsectolosis Y N Cricultarry problems Y N Hepatitis Y N Rapid weight gain or loss Y N Tobsectolosis Y N Cortisone treatments Y N Hepatitis Y N Repairatory disease Y N Venereal disease Authorization There is any change in my medical status, I will inform the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.										
Check (· ·			vape marijaana onew oner						
Y N AlDS/HIV Positive Y N Cough, persistent Y N Jaw pain Y N Shingles Y N Anaphylaxis Y N Cough up blood Y N Ridney disease or malfunction Y N Shingles Shin rash Shin rash Y N Anaphylaxis Y N Papidates Y N Epilepsy Y N Liver disease Y N Spina Bilida Y N Artificial pints Y N Fainting Y N Artificial joints Y N Food allergies Glatex, wood, metal, chemicals) Y N Artificial joints Y N Glaucoma Y N Mitral valve prolapse Y N Swelling of feet or ankles Y N Ashma Y N Headaches Y N Nervous problems Y N Swelling of feet or ankles Y N Northous problems Y N Reproblems Y N Reproduced Heart surgery Y N Replatitis Y N Girculatory problems Y N Herpes Y N Rapidation treatment Y N Robustic care Y N Tuberculosis Y N Girculatory problems Y N Hepatitis Y N Replatitis Y N Replatit			an control pane.							
Y N Anemia Y N Diabetes Influction Y N Spina Bifida Y N Epilepsy Y N Uiver disease Y N Spina Bifida Y N Spina Bifida Y N Artificial heart valves Y N Fainting Y N Artificial heart valves Y N Food allergies Y N Artificial points Y N Good allergies Y N Surgical implant Y N Artificial points Y N Surgical implant Y N Surgical implant Y N Stroke Y N St			☐ Y ☐ N Jaw pain	☐ Y ☐ N Shingles						
Y N Arthritis, Rheumatism Y N Epilepsy Y N Liver disease Y N Spina Bifida Y N Spina Bifida Y N Spina Bifida Y N Artificial heart valves Y N Fainting Y N Artificial joints Y N Galucoma Y N Mitral valve prolapse Y N Swelling of feet or ankles Y N Moreous problems Y N Swelling of feet or ankles Y N Moreous problems Y N Swelling of feet or ankles Y N Swel	☐ Y ☐ N Anaphylaxis	☐ Y ☐ N Cough up blood		\square Y \square N Shortness of breath						
Y N Artificial heart valves Y N Fainting Y N Material allergies Y N Stroke Glatex, wool, metal, chemicals) Y N Surgical implant Swelling of feet or ankles Y N Antificial joints Y N Glaucoma Y N Mitral valve prolapse Y N Swelling of feet or ankles Y N Appic (allergy prone) Y N Headaches Y N N Pacemaker/ Heart murmur Y N Pacemaker/ Heart murmur Pacemaker/ Heart surgery N Repeated or ankles Y N Pacemaker/ Heart problems Y N Pacemaker/ Heart problems Y N Pacemaker/ Heart problems Y N Pacemaker/ Heart surgery N N Tobsacco habit N N N N N N N N N										
Y N Artificial joints Y N Food allergies Catex, wool, metal, Y N Surgical implant Chemicals Y N Swelling of feet Or ankles Y N Ashma Y N Glaucoma Y N N Nervous problems Y N N Thyroid disease or malfunction N Nervous problems Y N N Thyroid disease or malfunction N Nervous problems Y N N Thyroid disease or malfunction N Nervous problems Y N N Thyroid disease or malfunction N Nervous problems Y N N Thyroid disease or malfunction N Nervous problems Y N N Thyroid disease or malfunction N N Nervous problems Y N N Nervous problems Y N N Nervous problems N N Nervous problems N N N N N N N N N	,	1 1 7		1						
Y N Asthma Y N Glaucoma Y N Mitral valve prolapse or ankles or ankle		· ·	(latex, wool, metal,							
Y N Atopic (allergy prone) Y N Headaches Y N N N N N N N N N	,	e e								
Y N Back problems Y N Heart murmur Y N Pacemaker/ Heart surgery Y N Tobacco habit P N Cancer Describe P N Rapid weight gain or loss Y N Tobacco habit P N N Chemical dependency Y N Chemical dependency Abnormal bleeding Y N Rapid weight gain or loss Y N Tuberculosis P N N Circulatory problems Y N Circulatory problems Y N Herpes Y N Respiratory disease Y N Venereal disease Y N Rheumatic/Scarlet fever Y N Venereal disease Y N Rheumatic/Scarlet fever Y N Venereal disease Y N Rheumatic/Scarlet fever Y N Venereal disease Y N Venereal dis				or ankles						
Y N Blood disease Y N Heart problems Heart surgery Y N Tobacco habit Tosalilitis Tosalilitis Y N Cancer Describe Y N Hemophilia/ Y N Rapid weight gain or loss Y N Tobacco habit Tosalilitis Tosalilitis Y N Circulatory problems Y N Herpes Y N Radiation treatment Y N Ulcer/Colitis Y N Cortisone treatments Y N High blood pressure Y N Rheumatic/Scarlet fever Y N Rheumatic/Scarlet fe	☐ Y ☐ N Back problems		*	,						
Y N Chemical dependency										
Abnormal bleeding Y N Rapid weight gain or loss Y N Tuberculosis Y N Radiation treatment Y N Radiation treatment Y N Respiratory disease Y N Venereal disease Y N Respiratory disease Y N Respiratory disease Y N Venereal disease Y N Respiratory disease Y N										
Are you currently taking any medications? If yes, list all: Do you have any drug allergies? If yes, list all: Authorization I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.			1 0 0	☐ Y ☐ N Tuberculosis						
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	I authorize the dentist to release all		ayment of benefits. I understand that I	I am financially responsible for all charges						
- Date			Date	e						

Payment is due in full at time of treatment, unless prior arrangements have been approved.

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