

WELCOME TO OUR OFFICE

Thank you for selecting our dental healthcare team. Our commitment to you is to provide the best possible care. To help us meet all your dental needs, please fill out BOTH sides of the form completely. If you have any questions, please ask.

PATIENT INFORMATION

Name \_\_\_\_\_ birth date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ zip \_\_\_\_\_  
Home phone \_\_\_\_\_ work \_\_\_\_\_ cell \_\_\_\_\_  
E-mail \_\_\_\_\_ camp \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Emergency contact \_\_\_\_\_ phone \_\_\_\_\_  
Who will pay this account? \_\_\_\_\_ relationship \_\_\_\_\_  
Address if different from above \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

DENTAL INSURANCE INFORMATION

Subscriber \_\_\_\_\_ birth date \_\_\_\_\_  
ID # \_\_\_\_\_ SS# \_\_\_\_\_  
Employer \_\_\_\_\_ group # \_\_\_\_\_  
Insurance company \_\_\_\_\_  
Do you have secondary insurance? \_\_\_\_\_  
Subscriber \_\_\_\_\_ birth date \_\_\_\_\_  
ID# \_\_\_\_\_ SS# \_\_\_\_\_  
Employer \_\_\_\_\_ group # \_\_\_\_\_  
Insurance company \_\_\_\_\_

AUTHORIZATION AND RELEASE

I authorize this office to release any information pertaining to treatment rendered to me or my child to my dental insurance carrier. I authorize my insurance to pay benefits to the dentist which are otherwise payable to me. I understand that the amount of payment from the insurance company is determined by the level of coverage purchased by my employer and may not cover the entire cost of treatment. I am responsible for payment of all services rendered on my behalf of myself or my dependents.

Signature \_\_\_\_\_ date \_\_\_\_\_

## DENTAL HISTORY

Do you have a specific dental problem? \_\_\_\_\_  
When was your last dental visit? \_\_\_\_\_  
How often did you see your dentist/hygienist? \_\_\_\_\_  
How often do you brush? \_\_\_\_\_ Floss? \_\_\_\_\_  
Do your gums bleed? \_\_\_\_\_ Do you grind your teeth? \_\_\_\_\_  
Have you experienced popping or clicking in your jaw? \_\_\_\_\_  
How do feel about the appearance of your smile? \_\_\_\_\_  
Do you have well water at your home? \_\_\_\_\_  
Have you had an unpleasant dental experience? \_\_\_\_\_  
Do you play sports or lift weights? \_\_\_\_\_ Do you wear a mouth guard? \_\_\_\_\_

## MEDICAL HISTORY

Are you in good health? \_\_\_\_\_ Have you been under a Dr.'s care in the past 2 yrs? \_\_\_\_\_  
Have you been hospitalized in the past five years? \_\_\_\_\_

Are you taking or have you taken FOSAMAX, ACTONEL or other BISPHOSPHONATES? \_\_\_\_\_  
Do you have DIABETES? \_\_\_\_\_ Is it controlled? \_\_\_\_\_  
Is there a family history of diabetes? \_\_\_\_\_  
Have you had a TRANSPLANT or ARTIFICIAL VALVES/JOINTS? \_\_\_\_\_  
Are you taking COUMADIN or other anticoagulants? \_\_\_\_\_  
Do you use TABACCO? \_\_\_\_\_ Are you interested in quitting? \_\_\_\_\_

Physician's name \_\_\_\_\_  
Please list medications \_\_\_\_\_

Do you take vitamins, herbal preparations, cough drops? \_\_\_\_\_  
WOMEN: Please let us know if you are pregnant or if you are taking birth control pills since treatment may need to be adjusted.

## PLEASE CIRCLE IF YOU HAVE ANY OF THE FOLLOWING;

High Blood Pressure	pacemaker/defibrillator	stent	bypass surgery
Breathing difficulty	sinus trouble	asthma	bronchitis
Pneumonia	chronic cough	tuberculosis	anemia
Kidney disease	hepatitis	dialysis	hemophilia
Rheumatoid arthritis	peripheral artery disease	glaucoma	hearing loss
Memory lapses	chemo/radiation	cancer	MRSA
Alcoholism	substance abuse	dizziness	panic attacks
Epilepsy	positive HIV	gastrointestinal problems	

ALLERGIES: please list \_\_\_\_\_