

W E L C O M E

Patient Information

Date _____ ID#/SS# _____
Patient _____
Address _____

City _____ State _____ Zip _____
Sex: M F Age _____ Birthdate _____
 Single Married Widowed Separated Divorced
Occupation _____
Employer _____
Employer Address _____
Employer Phone (_____) _____
Spouse's Name _____
Birthdate _____ SS# _____
Occupation _____
Spouse's Employer _____
Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____
Relationship to Patient _____
Insurance Co. _____
Group # _____
Is patient covered by additional insurance? Yes No
Subscriber's Name _____
Birthdate _____ SS# _____
Relationship to Patient _____
Insurance Co. _____
Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date

Phone Numbers

Home(_____) _____ Work(_____) _____ Ext _____ Spouse's Work(_____) _____
Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____
Home Phone (_____) _____ Work Phone (_____) _____

Dental History

Reason for today's visit _____
Former Dentist _____ City/State _____
Date of last dental visit _____ Date of last dental X-rays _____

Check (✓) if you have had any of the following:

- Bad breath
- Bleeding gums
- Blisters on lips or mouth
- Burning sensation on tongue
- Chew on one side of mouth
- Cigarette, pipe, or cigar smoking

- Clicking or popping jaw
- Dry mouth
- Fingernail biting
- Food collection between the teeth
- Foreign objects
- Grinding teeth
- Gums swollen or tender
- Jaw pain or tiredness

- Lip or cheek biting
- Loose teeth or broken fillings
- Mouth breathing
- Mouth pain, brushing
- Orthodontic treatment
- Pain around ear
- Periodontal treatment
- Sensitivity to cold

- Sensitivity to heat
- Sensitivity to sweets
- Sensitivity when biting
- Sores or growths in your mouth

How often do you floss? _____
How often do you brush? _____

Health History

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of fenpropion, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Check (✓) if you have had any of the following:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, persistent or bloody | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Swollen Neck Glands |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting or dizziness | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Problems | <input checked="" type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Bleeding abnormally, with extractions or surgery | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tumor or growth on head or neck |
| <input checked="" type="checkbox"/> Cancer | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hepatitis Type _____ | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Venereal Disease |
| <input checked="" type="checkbox"/> Chemotherapy | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Weight Loss, unexplained |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever | |
| <input type="checkbox"/> Congenital Heart Lesions | | <input type="checkbox"/> Shortness of Breath | |

Do you wear contact lenses? Yes No

Women:

Are you pregnant? Yes No Due date _____ Are you nursing? Yes No

Taking birth control pills? Yes No

Medications

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____

Phone(_____) _____

Allergies

- | | |
|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfas |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Latex | |

Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____