



Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

P a t i e n t I n f o r m a t i o n

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____
Last Name First Name Initial

Address _____ Home Phone _____

City _____ State _____ Zip _____

Email Address _____ Cellular Phone _____

Sex: M F Minor Single Married Long Term Partner Divorced Widowed Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of an emergency, who should we contact? _____ Phone _____

P r i m a r y I n s u r a n c e

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

A d d i t i o n a l I n s u r a n c e

Insured Name _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

D e n t a l H i s t o r y

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..... <input type="checkbox"/> | Loose Teeth or Broken Fillings <input type="checkbox"/> | Sensitivity to Sweets..... <input type="checkbox"/> |
| Bleeding Gums..... <input type="checkbox"/> | Orthodontic Treatment..... <input type="checkbox"/> | Sensitivity When Biting..... <input type="checkbox"/> |
| Blisters on Lips or Mouth <input type="checkbox"/> | Pain Around Ear..... <input type="checkbox"/> | Frequent Headaches..... <input type="checkbox"/> |
| Finger Nail Biting..... <input type="checkbox"/> | Periodontal Treatment..... <input type="checkbox"/> | Jaw, Head or Neck Injuries..... <input type="checkbox"/> |
| Grinding Teeth..... <input type="checkbox"/> | Sensitivity to Cold..... <input type="checkbox"/> | Jaw Difficulty: Clicking and/or Pain <input type="checkbox"/> |
| Lip or Cheek Biting..... <input type="checkbox"/> | Sensitivity to Heat..... <input type="checkbox"/> | Tooth Pain..... <input type="checkbox"/> |

M e d i c a l H i s t o r y

Physician's Name _____ Date of Last Visit _____

- | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--------------------------|-----|----|---|--------------------------|--------------------------|--------------------------------------|--------------------------|--------------------------|------------------|--------------------------|--------------------------|------------------------------------|--------------------------|--------------------------|----------------|--------------------------|--------------------------|-------------|--------------------------|--------------------------|--------------|--------------------------|--------------------------|--------------|--------------------------|--------------------------|------------|--------------------------|--------------------------|----------------|--------------------------|--------------------------|---------------|--------------------------|--------------------------|----------------------------------|--------------------------|--------------------------|
| <p>1. Are you currently under medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you ever had any serious illnesses or operations?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are you currently taking any medication?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
 Please describe: _____</p> <p>4. Do you smoke?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you use alcohol?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Do you use cocaine or other drugs?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Do you wear contact lenses?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>8. Have you had any allergic reactions to the following:</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 80%;"></td> <td style="width: 5%; text-align: center;">Yes</td> <td style="width: 15%; text-align: center;">No</td> </tr> <tr> <td>Local Anesthetics (e.g. novocaine).....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Penicillin or other Antibiotics.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Sulfa Drugs.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Barbiturates (sleeping pills).....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Sedatives.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Iodine.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Aspirin.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Codeine.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Other.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> <p>9. (Women Only) Are you:</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 80%;">Pregnant?.....</td> <td style="width: 5%; text-align: center;"><input type="checkbox"/></td> <td style="width: 15%; text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Nursing?.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Taking birth control pills?.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> | | Yes | No | Local Anesthetics (e.g. novocaine)..... | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin or other Antibiotics..... | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa Drugs..... | <input type="checkbox"/> | <input type="checkbox"/> | Barbiturates (sleeping pills)..... | <input type="checkbox"/> | <input type="checkbox"/> | Sedatives..... | <input type="checkbox"/> | <input type="checkbox"/> | Iodine..... | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin..... | <input type="checkbox"/> | <input type="checkbox"/> | Codeine..... | <input type="checkbox"/> | <input type="checkbox"/> | Other..... | <input type="checkbox"/> | <input type="checkbox"/> | Pregnant?..... | <input type="checkbox"/> | <input type="checkbox"/> | Nursing?..... | <input type="checkbox"/> | <input type="checkbox"/> | Taking birth control pills?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | Yes | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Local Anesthetics (e.g. novocaine)..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Penicillin or other Antibiotics..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sulfa Drugs..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Barbiturates (sleeping pills)..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sedatives..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Iodine..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Aspirin..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Codeine..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Pregnant?..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nursing?..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Taking birth control pills?..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Please check all that apply:

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

A s s i g n m e n t a n d R e l e a s e

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 Responsible Party _____ Date _____