Print Form

Patient Information

Date **Patient #** **Home Phone**

Name **SSN**

Last Name First Name Initial

Address

City **State** **Zip**

Sex F M **Age** **Birthdate**

Single Married Widowed Separated Divorced

Patient Employed by **Occupation**

Business Address **Bus Phone**

Whom may we thank for referring you?

In case of emergency who should be notified?

Primary Insurance

Person Responsible for Account

Last Name First Name Initial

Relation to Patient **Birthdate** **SSN**

Address (if different from patient's) **Phone**

City **State** **Zip**

Person Responsible Employed By **Occupation**

Business Address **Bus Phone**

Insurance Company

Contract # **Group #** **Subscriber #**

Name of other dependents covered under this plan

Dental History

Reason for Today's Visit _____ **Date of last dental care** _____

Former Dentist _____ **Date of last dental X-rays** _____

Address _____

Check if you have had problems with any of the following :

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

Medical 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 ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No **If yes, describe (below)**

_____

Have you ever had a blood transfusion? ☐ Yes ☐ No **If yes, give approximate dates (below)**

_____

(Women) Are you pregnant? ☐ Yes ☐ No **Nursing?** ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Check if you have or have had any of the following:

- ☐ Anemia
- ☐ Arhritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV / AIDS
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash

- [ ] Artificial Joints
- [ ] Asthma
- [ ] Back Problem
- [ ] Blood Disease
- [ ] Cancer
- [ ] Chemical Dependancy
- [ ] Chemotherapy
- [ ] Circulatory Problems
- [ ] Diabetes
- [ ] Epilepsy
- [ ] Fainting
- [ ] Glaucoma
- [ ] Headaches
- [ ] Heart Murmur
- [ ] Heart Problems
- [ ] Hemophilia
- [ ] Jaw Pain
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Mitral Valve Prolapse
- [ ] Pacemaker
- [ ] Radiation Treatment
- [ ] Respiratory Disease
- [ ] Rheumatic Fever
- [ ] Stroke
- [ ] Swelling of Feet / Ankle
- [ ] Thyroid Problems
- [ ] Tobacco Habit
- [ ] Tonsillitis
- [ ] Tuberculosis
- [ ] Ulcer
- [ ] Venereal Disease

MEDICATIONS

List medication you are currently taking:

ALLERGIES

Authorization

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all changes whether or not paid by insurance.

Signature _____ Date _____

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