Welcome!

Thank you for visiting us today! We are pleased to welcome you to our practice. To help us serve you better, please take a few moments to fill out the following forms as completely as you can. If you have any questions, just ask-we will be glad to help. We look forward to working with you to improve your dental health!

PATIENT INFORMATION

Date_____ Home phone_____

Name_____
Age____ Date of Birth_____ Sex: Male____Female____

Home Address_____Town_____Zip_____
E-Mail Address_____

Person financially responsible_____Home Phone_____Work Phone_____

Whom may we thank for referring you?_____

Name of your dentist_____city/town_____

INSURANCE

Father /
Husband's Name_____ _____
Address (if different from above)_____
_____
Home Phone_____Work Phone_____
Address (if different from above)_____
_____
Home Phone_____Work Phone_____
Employer_____
Social Security#_____Date of Birth_____
Do you have orthodontic insurance coverage? (Yes/No)
Plan Name_____
Address_____
Phone Number_____
Group#_____
Policy#_____

Mother /
Wife's Name_____
Address (if different from above)_____
_____
Home Phone_____ Work Phone_____
Address (if different from above)_____
_____
Home Phone_____Work Phone_____
Employer_____
Social Security#_____Date of Birth_____
Do you have orthodontic insurance coverage? (Yes/No)
Plan Name_____
Address_____
Phone Number_____
Group#_____
Policy#_____

DENTAL HISTORY

Date of last dental visit?_____ For what service?_____
How often do you brush?(daily)_____ Any injuries to mouth, teeth or head?_____
How often do you floss?_____ Any unhappy dental experiences?_____

Do you get headaches frequently?(YES/NO), (every day), (weekly), (monthly), (almost never)

Do you have (ringing) or (pressure) in your ears? (YES/NO)
Any mouth habits-thumbsucking, nail biting, mouth breathing, clenching, etc? _____

Please Complete Both Sides

MEDICAL HISTORY

Patient's physician_____City/State_____Phone_____

Date of last physical examination_____Results_____

Are you under the care of a physician now?-----YES/NO
Receiving any medications of drugs?----------YES/NO
Ever had surgery of been hospitalized?----------YES/NO
Is there excessive bleeding when cut?----------YES/NO
Do you take antibiotics for dental cleanings?----YES/NO

Medications_____
_____
Allergies_____
_____
_____

HAVE YOU HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CHECK (X)

__AIDS/HIV	___Cerebral Palsy	__Epilepsy	__Mumps
__Anemia	__Chicken Pox	__Fainting	__Sinus Problems
__Asthma	__Convulsions	__Hearing problems	__Thyroid Disease
__Bladder problems	__Diabetes	__Heart Problems	__Liver Disease
__Cancer	__Drug/Alcohol abuse	__Hepatitis	__Measles
__Mononucleosis	__ Rheumatic Fever	__Kidney Disease	__ Other

EMERGENCY INFORMATION

In the event of an emergency, whom should we contact?
Name_____Relationship_____Phone_____
Name_____Relationship_____Phone_____

AUTHORIZATION

I have received this Questionnaire and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment for myself, and I agree to notify the dentist if any changes in my health status should occur.

I authorize the dentist/staff to perform the necessary dental services I may need I also authorize the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist of dental group insurance benefits otherwise payable to me. I authorize use of the signature on all insurance submissions.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payments of all services rendered at time of treatment, unless prior arrangements have been approved.

Patient's Signature_____Date_____

Welcome!