

WELCOME

TO OUR PRACTICE

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

PATIENT INFORMATION

Today's Date _____ Birth Date _____ Patient Social Security # _____

Patient Name _____
(Last Name) (First Name) (Initial)

Street Address _____

City _____ State _____ Zip _____

Occupation _____ Male Female Single Married Widowed Divorced Separated

Patient Home Phone _____ Patient Work Phone _____

Employer _____ Employer Phone _____

Employer Address _____

In Case Of Emergency Contact:

Name _____ Relationship _____

Emergency Home Phone _____ Emergency Work Phone _____

Whom may we thank for referring you to us? _____

PRIMARY INSURANCE

Individual responsible for this account _____
(Last Name) (First Name) (Initial)

Relationship to Patient _____ Birth Date _____ Social Security # _____

Street Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

ADDITIONAL INSURANCE

Insured Individual's Name _____
(Last Name) (First Name) (Initial)

Relationship to Patient _____ Birth Date _____ Social Security # _____

Street Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Party Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ 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, for any services provided me. I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company, any other third party payer, state medical assistance agency, or any other governmental or private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for related services. I agree to pay for all charges not covered by a third party payer. I authorize a copy of this authorization to be used in place of the original. In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referral physician, and/or the provider, if any, who referred me here. I expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered without obtaining my signature on _____ and every claim submitted.

Signature _____ Date _____



FAMILY HEALTH INFORMATION

Some health conditions are the result of hereditary spinal weaknesses. Information that you can furnish us pertaining to your immediate family members (brothers, sisters, parents and grandparents) will give us a better understanding of your total health needs.

RELATIONSHIP TO YOU	HEALTH PROBLEMS ANY FAMILY MEMBER HAS HAD OR HAS NOW

MEDICATIONS

List medications you are currently taking

Pharmacy _____ Phone _____

- Aspirin
- Barbiturates
- Codeine
- Iodine
- Latex
- Local Anesthetic
- Penicillin
- Sulfa
- Other (please list) _____

CHECK ANY SYMPTOM(S) OR CONDITION(S) BELOW THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Depression/Nervousness | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Poor Appetite |
| <input type="checkbox"/> Arm Pain or Numbness | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Itching | <input type="checkbox"/> Prostate Problem |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rapid Heartbeat |
| <input type="checkbox"/> Back Pain or Numbness | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Lack of Bladder Control | <input type="checkbox"/> Rectal Bleeding |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Earache | <input type="checkbox"/> Leg Pain or Numbness | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Ear Discharge | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Feet Pain or Numbness | <input type="checkbox"/> Loss of Hearing | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Fever | <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Scars |
| <input type="checkbox"/> Bowel Changes | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Loss of Weight | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Shoulder Pain or Numbness |
| <input type="checkbox"/> Brights Disease | <input type="checkbox"/> Gas | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Measles | <input type="checkbox"/> Sore That Won't Heal |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Hand Pain or Numbness | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Stomach Aches or Pains |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Headache | <input type="checkbox"/> Mumps | <input type="checkbox"/> Sweats |
| <input type="checkbox"/> Change in Moles | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Nausea | <input type="checkbox"/> Swelling Ankles |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Neck Pain or Numbness | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Neuralgia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herpes | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chills | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> Hip Pain or Numbness | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Vision Flashes |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hives | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Vomiting Blood |

CHECK DEGREE OF HABITS BELOW. ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL.

	HEAVY	CASUAL	LIGHT	NONE		HEAVY	CASUAL	LIGHT	NONE		HEAVY	CASUAL	LIGHT	NONE
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sugar/Sugar Products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I certify that the above information is correct to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

