WELCOME

Date_____

Patient Information:

Social Security # ____-____-_____

Name_____ Birth Date_____ Home Phone ____-____-_____

Address_____ City_____ State_____ Zip _____

Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

E-mail address _____Cell phone ___-___-_____

Patient's or Parent's Employer _____ Work Phone ____-____-_____

Work - Business address _____ City_____ State_____ Zip _____

Whom may we thank for referring you? _____

Responsible Party:(If someone other than you is paying for your services)

Name_____ Relationship to patient _____

Billing address _____ City _____ State_____ Zip _____

Home Phone ____-____-_____ Cellphone ____-____-_____ Social Security # _____-_____-_____

Is this person currently a patient in our office? _____ Yes _____ No

In Event of Emergency:

Whom should we contact? _____ Relationship to patient _____

Home Phone ____-_____-_____ Work phone ____-_____-_____ Cellphone ____-_____-_____

Who is your medical doctor? _____ Office Phone ____-_____-_____

Insurance Information:

Name of Insured _____ Relationship to patient _____

Date of Birth of Insured _____ Social Security # of Insured _____-_____-_____

Insured's Employer _____ Phone # ____-_____-_____

Insurance Company Name _____ Phone # ____-_____-_____

Medications Taken at this Time:

Name of Medication	Reason for Medication
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient Medical History: (please circle)

1. Are you under medical treatment now? Yes / No
2. Have you ever been hospitalized for any surgical operation or serious illness? Yes / No
3. Do you use any kind of tobacco? Yes / No
4. Do you suffer from addiction to alcohol, Cocaine, or other drugs? Yes / No
5. Women Only*
   A) Are you pregnant or think you may be pregnant? Yes / No
   B) Are you nursing? Yes / No
   C) Are you taking birth control pills? Yes / No
6. Are you allergic to or have you had any reactions to the following?

Local Anesthetics	Yes / No
Penicillin	Yes / No
Sulfa Drugs	Yes / No
Erythromycin	Yes / No
Sedatives	Yes / No
Iodine	Yes / No
Aspirin	Yes / No
Latex	Yes / No

Other Allergies _____

Do you suffer from any of the following?

High blood pressure	Yes / No	Heart Disease / trouble	Yes / No	Tuberculosis	Yes / No
Heart attack	Yes / No	Cardiac Pacemaker	Yes / No	Easily winded	Yes / No
Rheumatic Fever	Yes / No	Heart Murmur	Yes / No	Stroke	Yes / No
Swollen Ankles	Yes / No	Angina / Chest pain	Yes / No	Sinus allergies	Yes / No
Fainting / Seizures	Yes / No	Anemia	Yes / No	Glaucoma	Yes / No
Asthma	Yes / No	Emphysema	Yes / No	Liver disease	Yes / No
Epilepsy	Yes / No	Radiation therapy	Yes / No	Cancer	Yes / No
Leukemia	Yes / No	Joint replacement	Yes / No		
Diabetes	Yes / No	Sexually trans. Disease	Yes / No	Hepatitis	Yes / No
Kidney Diseases	Yes / No	AIDS OR HIV Infection	Yes / No	Thyroid issue	Yes / No
Teeth grinding	Yes / No	Clicking or popping Jaw	Yes / No	Bleeding gums	Yes / No
		Braces or Orthodontics	Yes / No		

Authorization and Release

I certify that I have read and understand the above information. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my or my child during the period of such dental care to third party payers, insurance companies, and other medical and dental practitioners. I authorize and request my insurance company to pay claims directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the total bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient signature / Guardian _____ Date _____

Dentist Signature _____ Date_____