080923 Welcome form 125:1 7/25/08 11:37 AM Page 1 (Black plate)

Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental health care needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Date ____________________

Home # ____________________

Cell # ____________________

Patient Information (CONFIDENTIAL)

Name ______________________ Birthdate ____________ Soc. Sec. # ____________

Address ______________________ City ____________ State ______ Zip ______

Check Appropriate Box: ☐ Female ☐ Male ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or Parent's Employer ______________________ Work Phone ____________

Business Address ______________________ City ____________ State ______ Zip ______

Spouse or Parent's Name ____________ Employer ____________ Work Phone ____________

If Patient is a Student, Name of School / College ____________ City ____________ State ______

Whom May We Thank for Referring You? ______________________

Person to Contact in Case of Emergency ______________________ Phone ____________

Responsible Party

Name of Person Responsible for this Account ______________________ Relationship to Patient ____________

Address ______________________ Home Phone ____________

Social Security # ______________________ Birthdate ____________

Employer ______________________ Work Phone ____________

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Insurance Information

Name of Insured ______________________ Relationship to Patient ____________

Birthdate ______________________ Social Security # ____________

Name of Employer ______________________ Work Phone ____________

Address of Employer ______________________ City ____________ State ______ Zip ______

Insurance Company ______________________ Group # ____________

Ins. Co. Address ______________________ City ____________ State ______ Zip ______

DO YOU HAVE SECONDARY DENTAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured ______________________ Relationship to Patient ____________

Birthdate ____________ Social Security # ____________ Date Employed ____________

Name of Employer ______________________ Work Phone ____________

Address of Employer ______________________ City ____________ State ______ Zip ______

Insurance Company ______________________ Group # ____________

Ins. Co. Address ______________________ City ____________ State ______ Zip ______

How Much is your Deductible? ____________ How Much Have You Used? ____________ Max. Annual Benefit ____________

Over Please

If you could change something about your smile, what would it be? ____________________

Patient Medical History

Physician __________ *Office Phone* __________ *Date of Last Exam* __________

Previous Dentist __________ *Office Phone* __________ *Date of Last Exam* __________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s) including Fosomax (i.e. bisphosphonates) and any non prescription medications?	☐	☐
If yes, what medication(s) are you taking? __________		
4. Do you use tobacco?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Have you ever taken Phen-Fen or Redux?	☐	☐

	Yes	No
7. Are you allergic to or have you had any reactions to the following?	☐	☐
Local Anesthetics (e.g. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Latex	☐	☐
Sedatives	☐	☐
Codeine	☐	☐
Aspirin	☐	☐
Metal/Acrylic	☐	☐
Other	☐	☐
8. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills	☐	☐

9. Do you have or have you had any of the following?

Yes	No		Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	AIDS/HIV Positive	☐	☐	Chest Pains	☐	☐	Frequent Headaches	☐	☐	Irregular Heartbeat	☐	☐	Scarlet Fever
☐	☐	Alzheimer's Disease	☐	☐	Cold Sores/Fever Blisters	☐	☐	Genital Herpes	☐	☐	Kidney Problems	☐	☐	Shingles
☐	☐	Anaphylaxis	☐	☐	Congenital Heart Disorder	☐	☐	Glaucoma	☐	☐	Leukemia	☐	☐	Sickle Cell Disease
☐	☐	Anemia	☐	☐	Convulsions	☐	☐	Hay Fever	☐	☐	Liver Disease	☐	☐	Sinus Trouble
☐	☐	Angina	☐	☐	Cortisone Medicine	☐	☐	Heart Attack/Failure	☐	☐	Low Blood Pressure	☐	☐	Osteoporosis
☐	☐	Arthritis/Gout	☐	☐	Diabetes	☐	☐	Heart Murmur	☐	☐	Lung Disease	☐	☐	Stomach/Intestinal Disease
☐	☐	Artificial Heart Valve	☐	☐	Drug Addiction	☐	☐	Heart Pace Maker	☐	☐	Mitral Valve Prolapse	☐	☐	Stroke
☐	☐	Artificial Joint	☐	☐	Easily Winded	☐	☐	Heart Trouble/Disease	☐	☐	Pain in Jaw Joints	☐	☐	Swelling of Limbs
☐	☐	Asthma	☐	☐	Emphysema	☐	☐	Hemophilia	☐	☐	Parathyroid Disease	☐	☐	Thyroid Disease
☐	☐	Blood Disease	☐	☐	Epilepsy or Seizures	☐	☐	Hepatitis A	☐	☐	Psychiatric Care	☐	☐	Tonsillitis
☐	☐	Blood Transfusion	☐	☐	Excessive Bleeding	☐	☐	Hepatitis B or C	☐	☐	Radiation Treatments	☐	☐	Tuberculosis
☐	☐	Breathing Problems	☐	☐	Excessive Thirst	☐	☐	Herpes	☐	☐	Recent Weight Loss	☐	☐	Tumors or Growths
☐	☐	Bruise Easily	☐	☐	Fainting Spells / Dizziness	☐	☐	High Blood Pressure	☐	☐	Renal Dialysis	☐	☐	Ulcers
☐	☐	Cancer	☐	☐	Frequent Cough	☐	☐	Hives or Rash	☐	☐	Rheumatic Fever	☐	☐	Venereal Disease
☐	☐	Chemotherapy	☐	☐	Frequent Diarrhea	☐	☐	Hypoglycemia	☐	☐	Rheumatism	☐	☐	Yellow Jaundice

Patient Dental History

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
a) Clicking?	☐	☐
a) Pain (joint, ear, side of face)?	☐	☐
a) Difficulty in opening or closing?	☐	☐
a) Difficulty in chewing?	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you had any orthodontic work?	☐	☐
13. Have you ever had any prolonged bleeding following extractions?	☐	☐
14. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
15. Have you ever had instructions on the care of your gums?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions 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 me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay 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 actual bill for the services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I consent to any advisable and necessary dental treatment to be administered by the dentist or staff for diagnostic purposes or dental restoration.

X ____________________ ____________________

Signature of patient or parent if minor *Date*