## Welcome



We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

## **Patient Information**

Address	Name					Soc. Sec. #	
State	Last Name	First	Name	Init	ial		
Email   Single   Married   Swidowed   Separated   Divorced   Div	Address				45		
ice   M   F Age	City	,	State	Zip		Home Phone	
Partient Employed by Occupation Business Phone  Business Address Business Entail Whom may we thank for referring you?  Notify in case of emergency Home Phone Business Phon	Cell Phone		Email				
Business Address Business Brail  Business Brail  Short may we thank for referring you?  Self Phone Business Phone Business Phone  Small  Primary Insurance  Primary Insurance  Primary Insurance  Person Responsible for Account  Last Name First Name Initial  Relation to Patient Burladate Soc. Sec. #  Induction of Patient from patient) Hone Phone  Sity State Zip  Person Responsible Employed by Occupation  Business Address Business Phone  Business Phone  Additional Insurance Email  Additional Insurance  Spatient covered by additional insurance? Yes No  Subscriber #  State Zip Burladate  Additional Insurance  Spatient covered by additional insurance? Yes No  Subscriber Rame Relation to Patient Burladate  Soc. Sec. #  Additional Insurance  Business Phone  Business Phone  Business Phone  Business Phone  Phone Burladate  Spatient covered by additional insurance? Yes No  Subscriber Rame Relation to Patient Burladate  Soc. Sec. #  Sity State Zip Home Phone  Email  Business Phone  Business Phone  Business Phone  Business Phone  Business Phone  Business Phone  Subscriber Employed by Business Phone  Business Phone  Business Phone  Additional First Name Business Phone  Business	Sex □ M □ F Age	Birthdate	*	_ 🗆 Single 🗆	Married C	☐ Widowed ☐ Separated ☐ Divorced	
Ausiness Email  Whom may we thank for referring you?  Solvify in case of emergency  Business Phone  Simil  Primary Insurance  Person Responsible for Account  Last Name  Birthdate  Soc. Sec. #  Additional Insurance  Susiness Phone  Susiness Phone  Susiness Address  Susiness Address  Susiness Address  Business Phone  Susiness Address  Business Phone  Susiness Address  Susiness Address  Susiness Address  Susiness Address  Susiness Address  Susiness Phone  Susiness Address  Susiness Address  Susiness Address  Susiness Phone  Susiness Address  Susiness Address  Susiness Phone  Susiness Address  Susiness Phone  Susiness Phone  Susiness Address  Susiness Phone  Susiness Email  Susiness Phone  Susiness Email  Susiness Phone  Susiness Email  Susiness Phone  Susiness Email  Susines	Patient Employed by					Occupation	
Whom may we thank for referring you?    Home Phone	Business Address					Business Phone	
Notify in case of emergency Business Phone Business							
Primary Insurance   Prim							
Primary Insurance  Person Responsible for Account  Last Name  Birthdate Soc. Sec. #  Address (if different from patient) Birthdate State Zip Bell Hone Business Address Business Phone Business Email Business Address Business Email B							
Person Responsible for Account  Last Name  Birthdate Soc. Sec. #  Home Phone  Relation to Patient from patient)  Home Phone  State Zip Cerson Responsible Employed by Soc. Sec. #  State Susiness Address Business Phone Susiness Address Susscriber #  Subscriber #  Subscriber #  Subscriber Mame of other dependents under this plan  Additional Insurance Spatient covered by additional insurance?   Yes   No   Subscriber Name	Cell Phone			Business Pl	none		
Person Responsible for Account    Last Name   First Name   Initial	Email						
Relation to Patient Birthdate Soc. Sec. #			Pri	mary Insu	irance		
Relation to Patient Birthdate Soc. Sec. #	Person Responsible for Account						
Additional Insurance spatient covered by additional insurance? State Spatient covered by additional insurance? Spatient covered by additional insurance and additional		,	Last Name			First Name	Initial
State Zip	Relation to Patient		Birthdate			Soc. Sec. #	
Email   Occupation   Occupati	Address (if different from patient)					Home Phone	
Person Responsible Employed by	City	THE CANADA TO THE RESIDENCE		State		Zip	
Business Address Business Phone Business Email Phone Subscriber # Subscriber # Subscriber # Soc. Sec. # State Zip Home Business Phone Business Email Busines	Cell Phone					Email	
Susiness Email	Person Responsible Employed by					Occupation	
nsurance Company Phone	Business Address					Business Phone	
Additional Insurance    Subscriber #   Subscriber #	Business Email				123		
Additional Insurance  spatient covered by additional insurance?	Insurance Company					Phone	
Additional Insurance  s patient covered by additional insurance?	Insurance Email				=		
Additional Insurance  s patient covered by additional insurance?	Contract #		Group #			Subscriber #	
s patient covered by additional insurance?	Name of other dependents under this plan						
Subscriber Name			Addi	itional Ins	surance		
Soc. Sec. #  SityStateZipHome Phone  Cell Phone	Is patient covered by additional insurance?	☐ Yes ☐	No				
City	Subscriber Name	Re	elation to Patient_			Birthdate	
Cell Phone Email	Address (if different from patient)	74.5.E. 75			Soc. Sec.	#	
Business Phone Business Email  Insurance Company  Phone  Insurance Email  Contract # Group # Subscriber #	City		State	Zip		Home Phone	
Business Phone Business Email  Insurance Company  Phone  Insurance Email  Contract # Group # Subscriber #	Cell Phone					Email	
Phone							
Phone	Business Email					2	
Subscriber #   Subscriber   Subscriber #   Subscriber   Subscriber #   Subscriber						Phone	
Contract # Subscriber #							
						Subscriber #	
							X

Please complete both sides.

## **Dental History**

What would you like us to do today?_			Are you	in dental discomfort today	?					
			201							
	ner Dentist Address tist's Email Phone									
Date of last dental care										
			iasi x-rays _			3				
Check ( ✓ ) yes or no if you have ha  ☐ Y ☐ N Bad breath  ☐ Y ☐ N Bleeding gums  ☐ Y ☐ N Clicking or popping jaw  How often do you brush?	ad problems with any of the following:  Y N Food collection between teeth N Orinding or clenching teeth Y N Loose teeth or broken fillings			☐ Y ☐ N Periodontal treatment ☐ Y ☐ N Sensitivity to cold ☐ Y ☐ N Sensitivity to hot		☐ Y ☐ N Sensitivity to sweets ☐ Y ☐ N Sensitivity when biting ☐ Y ☐ N Sores or growths in mouth				
How do you feel about the appearance										
Have you ever experienced an adver	- 9									
Other information about your dental				ACCUSE OF THE PARTY OF THE PART						
omer morning in the definition	remain or pre-r	out treatment								
		Med	ical Histo	ory						
Physician's name				Phone						
Date of last visit		Have you had any serious il	lnesses or op	erations? 🗆 Y 🗀 N						
If yes, describe			328							
Are you currently under physician can	re? 🗆 Y 🗆 N	If yes, describe								
Have you ever had a blood transfusion	n? 🗆 Y 🗅 N	If yes, give approximate	e dates							
Have you ever taken Fen-Phen/Redux	Y DY DN	Į.								
Have you ever used a bisphosphonate	medication? B	rand names include Fosam	ax, Actonel, A	telvia, Didronel and Boniv	a. 🗆 Y 🗆 N					
Women: Are you pregnant? □ Y □	N Nursing?	Y □ Y □ N Taking birt	th control pill	s? 🗆 Y 🗅 N						
Check ( ✓ ) yes or no whether you h	ave had any of	the following:								
☐ Y ☐ N AIDS/HIV Positive	$\square$ Y $\square$ N	Cough, persistent	$\square$ Y $\square$ N	Jaw pain	$\square$ Y $\square$ N	Shingles				
☐ Y ☐ N Anaphylaxis	$\square$ Y $\square$ N	Cough up blood	$\square$ Y $\square$ N	Kidney disease or	$\square$ Y $\square$ N	Shortness of breath				
☐ Y ☐ N Anemia				malfunction Liver disease	$\square$ Y $\square$ N					
☐ Y ☐ N Arthritis, Rheumatism		Epilepsy		Material allergies		Spina Bifida				
☐ Y ☐ N Artificial heart valves ☐ Y ☐ N Artificial joints			ar an	(latex, wool, metal,		Stroke Surgical implant				
Y N Asthma		Glaucoma		chemicals)		Swelling of feet				
☐ Y ☐ N Atopic (allergy prone)		Headaches		Mitral valve prolapse Nervous problems	-1	or ankles				
☐ Y ☐ N Back problems	$\square$ Y $\square$ N	Heart murmur		Pacemaker/	$\square$ Y $\square$ N	Thyroid disease or				
☐ Y ☐ N Blood disease		Heart problems		Heart surgery	$\Box v \Box v$	malfunction Tobacco habit				
□ Y □ N Cancer	Describe	Hemophilia/		Psychiatric care						
☐ Y ☐ N Chemical dependency ☐ Y ☐ N Chemotherapy	<b>J</b> 1 <b>J</b> 1	Abnormal bleeding		Rapid weight gain or loss		Tuberculosis				
☐ Y ☐ N Circulatory problems	$\square$ Y $\square$ N	5-10-10-10- <b>4</b> -10-10-2		Radiation treatment Respiratory disease	$\square$ Y $\square$ N	Ulcer/Colitis				
☐ Y ☐ N Cortisone treatments		The state of the s		Rheumatic/Scarlet fever	$\square$ Y $\square$ N	Venereal disease				
Is patient currently taking any medicat		High blood pressure			oe liet all					
is patient currently taking any medical	ions: ii yes, iis	t an.	Does pane	nt have drug allergies? If y	es, nst an:					
			-			_				
			2							
		Aut	horizatio	on						
I have reviewed the information on the to help determine appropriate and he	is questionnair althful dental t	e, and it is accurate to the lareatment. If there is any ch	oest of my kno ange in my m	owledge. I understand that edical status, I will inform	this informatio the dentist.	n will be used by the dentist				
I authorize the insurance company I authorize the use of this signature o	indicated on n all insurance	this form to pay to the submissions.	dentist all in	surance benefits otherwi	se payable to	me for services rendered.				
I authorize the dentist to release all whether or not paid by insurance.	information	necessary to secure the pa	yment of ben	efits. I understand that I	am financially	responsible for all charges				
Signature				Date	<u>.</u>					
				rrangamente have been an						