Welcome to our practice!

Patient Name:_____ _____ ____ _____
Last First MI Preferred Name

Title:_____ **Gender:** ❑ Male ❑ Female **Family Status:** ❑ Married ❑ Single ❑ Child ❑ Other
Mr./Ms./Mrs.

Birthdate: _____ **SS#**_____

E-mail address:_____ **Best time to call:**_____

Phone:_____ _____ _____
Home Mobile Work

Address:_____

_____

Employer Name: _____

Employer Address: _____

_____

Whom may we thank for referring you to our practice? _____

In case of an emergency who should we notified? _____
Name

_____
Phone#

Primary Dental Insurance

Name of Insured:_____ _____ ____
Last First MI

Patient's Relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other_____

Insurance Plan Name:_____

Medical Information

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health? ❑Yes ❑ No

Within the past year, have there been any changes in your general health? ❑Yes ❑ No

What is the date (or approximate date) of your last medical exam? _____

Your Primary Care Physician: _____
Name Phone #

_____
Address

_____
Address

Indicate which of the following you have had or have at present time. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

❑ Pre-Med - Amoxicillin	❑ Pre-Med - Clindamycin	❑ AIDS/HIV+/ARC	❑ Alcohol/Drug Abuse
❑ Allergy - Aspirin	❑ Allergy - Codeine	❑ Allergy - Erythromycin	❑ Allergy - Latex
❑ Allergy - Penicillin	❑ Allergy - Sulfa	❑ Allergy - Clindamycin	❑ Allergy - Metal
❑ Anemia	❑ Arthritis	❑ Artificial Heart Valve	❑ Artificial Joints
❑ Aspirin Daily	❑ Hay Fever	❑ Asthma	❑ Autoimmune Disease
❑ Bisphosphonates	❑ Bleeding Disorder	❑ Blood Thinner	❑ Blood Transfusion
❑ Chemo/Radiation	❑ Cortisone/Steroids	❑ Coumadin	❑ Diabetes
❑ Diverticulitis/Colitis	❑ Emphysema	❑ Facial Radiation	❑ Fainting/Dizziness
❑ Frequent Headaches	❑ Glaucoma	❑ High Blood Pressure	❑ Heart Murmur
❑ Heart Problems	❑ Hepatitis/Jaundice	❑ Herpes	❑ HPV
❑ Kidney Disease	❑ Malignancies	❑ Numbness/Tingling	❑ Pacemaker
❑ Persistent Cough	❑ Plavix	❑ Pradaxa	❑ Psychiatric Disorder
❑ Rheumatic Fever	❑ Shortness of Breath	❑ Sinus Problem	❑ Stroke
❑ Thyroid Problems	❑ TMJ Dysfunction	❑ Tuberculosis	❑Xarelto

WOMEN ONLY: Are you pregnant? ❑Yes ❑ No

Please mark any of the following to indicate YES in response to the question:

❑ Have you ever had complications following dental treatment?
❑ Are you currently under the care of a physician due to specific condition?
❑ Have you ever been hospitalized within the last 5 years due to a surgery or illness?
❑ Are you currently taking any prescription or non-prescription medications?
❑ Do you use tobacco (smoking or chewing)?
❑ Do you require the use of corrective lenses (contacts or glasses)?
❑ Do you have and other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

_____

_____

List all medications, drugs, pills, or herbal remedies, including regular dosages of aspirin:

_____

_____

_____

_____

_____

_____

_____

Pre-Med patients: Please list why Pre-Med is needed: _____

AUTHORIZATION

- I acknowledge that I have received ALL questions on this questionnaire and had responded accordingly. There are no other medical condition or medications/allergies that have not been listed.
- I am aware that I must notify the practice of any future changes.
- I certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge.
- I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.
- I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.
- I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners.
- I authorize the payment from my insurance carrier to submit payment directly to the dental practice to be applied directly to any outstanding balance on my account.
- **I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance.**
- **I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).**

Signature:_____

Relationship to patient:_____

Date:_____