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

Today's Date__________________________ Referred By____

Name____ I prefer to be called____________________
Last Name First Name Middle Initial

Address____ City____________________ Zip__________

Birthdate_______________ Single______ Married______ Partner______ Divorced______ Widowed______

Phone (H)_________________________ (W) _________________________ (Cell) ________________________

E-Mail Address____

Appointment Confirmation Preference: **Text** ☐ **Email** ☐ **Phone**: Home ☐ Work ☐ Cell ☐

Employer_______________________________________ Occupation___________________________________

Soc. Sec.#_____________________________________ Driver's Lic.#________________________________

EMERGENCY CONTACT

Name____ Relation_____________________________

Phone (H)_________________________ (W) _________________________ (Cell) ________________________

PRIMARY INSURANCE

Responsible Party____ Soc. Sec. #_________________________

Birthdate_________________________ Relation to Patient____________________ Phone(H)______________

Employer__________________________ Occupation_________________________ Phone(W)______________

Insurance Carrier_________________________________ Phone_________________ Group#_____________

Address of Carrier____

SECONDARY INSURANCE

Responsible Party____ Soc. Sec. #_________________________

Birthdate_________________________ Relation to Patient____________________ Phone(H)______________

Employer__________________________ Occupation_________________________ Phone(W)______________

Insurance Carrier_________________________________ Phone_________________ Group#_____________

Address of Carrier____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

DENTAL HISTORY

Why have you come to the dentist today?

____

Are you currently in pain? Yes No

Do you require antibiotics before dental treatment? Yes No

Do you floss daily? Yes No Do you brush daily? Yes No

Are your teeth sensitive to heat, cold, or anything else?

____

Do you or have you used tobacco products? Yes No

Previous Dentist______________ City________________

Last Visit Date____________ Last X-rays Taken__________

Are you happy with the way your smile looks? Yes No

If not, what would you change? ______________________

____

Would you like the dentist to recommend treatment for whiter teeth? Yes No

MEDICAL HISTORY

Physician's Name______________________________

Phone Number______________ Last Visit Date________

List any prescription or over the counter drugs you're taking

____

____

Kaiser Number______________________________

FOR WOMEN:

Are you taking oral contraceptives? Yes No

Are you pregnant/trying? Yes No

Nursing? Yes No

Do you have or have you experienced the following? Please circle:

Y N Abnormal Bleeding
Y N Alcohol Abuse
Y N Aids/HIV Positive
Y N Anemia
Y N Arthritis
Y N Artificial Heart Valve
Y N Artificial Joints
Y N Asthma
Y N Blood Transfusion
Y N Cancer
Y N Chemotherapy
Y N Chicken Pox

Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Drug Abuse
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Fever Blisters
Y N Glaucoma
Y N Headaches
Y N Heart Attack
Y N Heart Murmur

Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N High Blood Pressure
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Persistent Cough
Y N Psychiatric Problems
Y N Radiation Treatment

Y N Rheumatic Fever
Y N Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Steroid Therapy
Y N Stroke
Y N Thyroid Problems
Y N Tonsillitis
Y N Ulcers
Y N Venereal Disease

Please list any serious medical condition(s) that you have experienced:______________________________

Are you allergic to any of the following? Please circle:

Y N Aspirin
Y N Barbiturates
Y N Codeine

Y N Dental Anesthetics
Y N Jewelry / Metals
Y N Latex

Y N Penicillin
Y N Sedatives
Y N Sulfa Drugs

Y N Tetracycline
Y N Other
____

I authorize the dental staff to perform the necessary dental services I may need. I affirm the information I have given is correct to the best of my knowledge. It will be used by the dentist to help determine appropriate and healthful dental treatment. It is my responsibility to inform this office of any changes in my medical status. I understand that I am financially responsible for all charges not paid by insurance. I understand that missed appointments and appointments cancelled without 24 hours notice are subject to a $25 fee per appointment.

Signature of Patient or Guardian ______________________________ Date ________________

Doctor's Signature ______________________________ Date________________

DATE	EXCEPTIONS	PATIENT'S SIGNATURE	REVIEWED BY