# 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

Date_____________

Name________________________________________________________ Soc.Sec#______________

Last First Initial

Spouse____________________________________________________________________

Address__________________________________________ City________________________

State____________ Zip_________ Phone______________________ Cell____________________

Sex ☐M ☐F Age________ Birth date______________ ☐Single ☐Married ☐Widowed ☐Divorced

Patient Employed by___________________________ Occupation___________________________

Business Address___________________________________ Business Phone___________________

Whom may we thank for referring you?___________________________________________________

Notify in case of emergency_____________________ Home Phone___________ Work ___________

## Primary Insurance

Person Responsible for Acct.____________________________________________________________

Relationship to Patient___________________________ Birth date_____________________________

Address(if different from patient)_______________________________________________________

City_______________________ State_________________ Zip______________ Phone___________

Person Responsible Employed by__________________________ Occupation___________________

Business Address___________________________________ Business Phone___________________

Insurance Company_________________________________ Phone______________________________

Group#_____________________________ Soc.Sec.# or Ins.ID# __________________________

Names of Other Dependents Under this Plan_______________________________________________

## Additional Insurance

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber Name___________________ Relationship to Patient______________ Birth date_________

Address(if different from patient)_______________________________________________________

City_______________________ State_________________ Zip______________ Phone___________

Subscriber Employed by______________________________ Occupation_________________________

Insurance Company_________________________________ Phone______________________________

Group#___________________________ Soc.Sec.# or Ins.ID#_____________________________

Names of Other Dependents Under this Plan_______________________________________________

**(Please Complete Both Sides)**

## HEALTH HISTORY

1. Are you having pain or discomfort at this time? ............ YES NO
2. Do you feel very nervous about having dental treatment? ............ YES NO
3. Have you ever had a bad experience in the dental office? ............ YES NO
4. Have you been a patient in the hospital during the past two years? ............ YES NO
5. Have you been under the care of a medical doctor during the past two years? ............ YES NO

   Physicians Name: ______________________

   Address: ______________________ Phone: ______________________
6. Have you taken any medicine or drugs during the past two years? ............ YES NO
7. Are you now taking any medication, drugs, or pills? ............ YES NO

   If yes, please list: ______________________
8. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? ............ YES NO

   If yes, please list: ______________________

9. Indicate which of the following you have had or have at present. Circle YES or NO to each item:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Heart Failure | YES | NO | Emphysema | YES | NO | Hepatitis A,B,C or D | YES | NO |
| Heart Disease or Attack | YES | NO | Cosmetic Surgery | YES | NO | (circle one above) | | |
| Angina Pectoris | YES | NO | Tuberculosis (TB) | YES | NO | Liver Disease | YES | NO |
| High Blood Pressure | YES | NO | Asthma | YES | NO | Yellow Jaundice | YES | NO |
| Heart Murmur | YES | NO | Hay Fever | YES | NO | Blood Transfusion | YES | NO |
| Rheumatic Fever | YES | NO | Sinus Trouble | YES | NO | Bruise easily | YES | NO |
| Congenital Heart Lesions | YES | NO | Allergies or Hives | YES | NO | Hemophilia | YES | NO |
| Scarlet Fever | YES | NO | Diabetes | YES | NO | Venereal Disease | | |
| Artificial Heart Valve | YES | NO | Thyroid Disease | YES | NO | (Syphilis, Gonorrhea) | YES | NO |
| Heart Pacemaker | YES | NO | X-ray or Cobalt Treatment | YES | NO | Cold Sores | YES | NO |
| Heart Surgery | YES | NO | Chemotherapy (Cancer, Leukemia) | YES | NO | Fever Blisters | YES | NO |
| Artificial Joints | YES | NO | Arthritis | YES | NO | Epilepsy or Seizures | YES | NO |
| Metal placed from surgery | YES | NO | Hernia | YES | NO | Sickle Cell Disease | YES | NO |
| Anemia | YES | NO | Rheumatism | YES | NO | Fainting or Dizzy Spells | YES | NO |
| Stroke | YES | NO | Cortisone Medicine | YES | NO | Shunts/Stints | YES | NO |
| Kidney Trouble | YES | NO | Glaucoma | YES | NO | Psychiatric Treatment | YES | NO |
| Ulcers | YES | NO | AIDS | YES | NO | Other(explain) ____________ | | |

10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired ............ YES NO
11. Have you any history of chemical dependency or are you a recovering chemical dependent? ............ YES NO
12. Have you used any cocaine or methamphetamines within the last 6 hours? ............ YES NO
13. Have you lost or gained more than 10 pounds in the past year? ............ YES NO
14. Do you ever wake from sleep short of breath? ............ YES NO
15. Are you on a special diet? ............ YES NO
16. Do you use any herbal medications ? ............ YES NO
17. Has your medical doctor ever said you have a cancer or tumor? ............ YES NO
18. Do you have any disease, condition, or problem not listed? ............ YES NO

**FOR WOMEN ONLY:**
Are you Pregnant? ☐YES ☐NO If YES, what month? ______ Are you taking birth control pills? ☐YES ☐NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

**CONSENT:**

The undersigned hereby authorizes Doctor to take X-rays, study models, or any other diagnostic aides deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) ______________________ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk.

Patient ______________________ Date ______________________

Parent or responsible party ______________________ Relationship to Patient ______________________