Welcome

Date _____

Patient's Name _____ **Date of Birth** _____ ☐ Male ☐ Female
Last First Initial

If Child: Parent's Name _____

How do you wish to be addressed _____

Residence - Street _____

City _____ State ____ Zip _____

Business Address _____

Telephone: Res. _____ **Bus.** _____

Cell Phone # _____

eMail _____

Patient/Parent Employed By _____

Present Position _____

How Long Held _____

Spouse/Parent Name _____

Spouse Employed By _____

Present Postion _____

How Long Held _____

Who is Responsible for this account _____

Drivers License No. _____

Method of Payment: Check ☐ Cash ☐ Credit Card ☐

Purpose of Call _____

Other Family Members in this Practice _____

_____

Whom may we thank for this referral _____

General Dentist Name: _____

Last Dental Checkup: _____

Someone to notify in case of emergency not living with you _____

_____

DENTAL INSURANCE 1ST COVERAGE

Employee Name _____ **Date of Birth** _____

Employer Name _____ Yrs. _____

Name of Insurance Co. _____

Address _____

_____

Telephone _____

Program or policy # _____

SOCIAL SECURITY NO. _____

Union Local or Group _____

DENTAL INSURANCE 2ND COVERAGE

Employee Name _____ Date of Birth _____

Employer Name _____ Yrs. _____

Name of Insurance Co. _____

Address _____

_____

Telephone _____

Program or policy # _____

SOCIAL SECURITY NO. _____

Union Local or Group _____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's)health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I attest to the accuracy of the information on this page.

_____

PARENT OR GUARDIAN SIGNATURE

DATE _____

OVER --------->

MEDICAL HISTORY

Patient's Name _____
Last First Initial Date of Birth

CIRCLE THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION!

1. Physician's Name _____
   Address _____
   _____
2. Are you under a physician's care? ..... YES NO
   Since when _____ Why _____
3. When was your last complete physical exam? _____
4. Are you taking any medication or substances? ..... YES NO
   (If yes, please list medications in comments section or on the back of this form.)
5. Do you routinely take health related substances? ..... YES NO
6. Are you allergic to any medications or substances? ..... YES NO
7. Do you have any other allergies ..... YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? ..... YES NO
9. Are you sensitive to any metals or latex? ..... YES NO
10. Are you pregnant or suspect you may be? ..... YES NO
11. Do you use any birth control medications? ..... YES NO
12. Have you ever been treated for or been told you might have heart disease? ..... YES NO
13. Do you have a pacemaker or an artificial heart valve implant? ..... YES NO
14. Have you ever had rheumatic fever? ..... YES NO
15. Are you aware of any heart murmurs? ..... YES NO
16. Do you have high or low blood pressure? ..... YES NO
17. Have you ever had a serious illness or major surgery? ..... YES NO
    If so, explain _____
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? ..... YES NO
19. Do you have inflammatory diseases, such as arthritis or rheumatism? ..... YES NO
20. Do you have any artificial joints/prosthesis? ..... YES NO
21. Do you have any blood disorders, such as anemia, leukemia, etc? ..... YES NO
22. Have you ever bled excessively after being cut or injured? ..... YES NO
23. Do you have any stomach problems? ..... YES NO
24. Do you have any kidney problems? ..... YES NO
25. Do you have any liver problems? ..... YES NO
26. Are you diabetic? ..... YES NO
27. Do you have asthma? ..... YES NO
28. Do you have epilepsy or seizure disorders? ..... YES NO
29. Do you or have you had venereal disease? ..... YES NO
30. Have you tested HIV positive? ..... YES NO
31. Do you have AIDS? ..... YES NO
32. Have you had or do you test positive for hepatitis? ..... YES NO
33. Do you or have you had T.B.? ..... YES NO
34. Do you smoke, chew, use snuff or any other forms of tobacco? ..... YES NO
35. Do you consume alcoholic beverages? ..... YES NO
36. Do you habitually use controlled substances? ..... YES NO
37. Have you had psychiatric treatment? ..... YES NO
38. Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? ..... YES NO
39. Do you have any disease condition, or problem not listed? If so, explain _____
    _____
40. Is there anything else we should know about your health that we have not covered in this form?
    _____
41. Would you like to speak to the Doctor privately about any problem? ..... YES NO

ADDITIONAL COMMENTS:

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

Updates:

Patient/Guardian _____ Doctor's Initials _____ Date _____

Patient/Guardian _____ Doctor's Initials _____ Date _____

Patient/Guardian _____ Doctor's Initials _____ Date _____

Patient/Guardian _____ Doctor's Initials _____ Date _____