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Welcome! We would like to get to know you better...

PATIENT INFORMATION

Name _____ If Child, Parents Name _____
 Address _____ City _____ ST _____ Zip _____
 Social Security # _____ Date of Birth _____
 Phone # _____ Cell # _____ Email Address _____
 Employer _____ Work # _____
 Spouses Name _____ Do you have any children? _____
 Emergency Contact _____ Relationship _____ Phone # _____
 Do you prefer a certain day/time for appointments? Yes No If Yes, what day? M T W TH F AM or PM
 How did you hear about our office? _____ When was your last dental visit? _____
 Your reason for leaving your last dentist? _____
 Are you dissatisfied with your teeth? Yes No If 'yes', what would you change? _____
 What is your current dental concern? _____
 Do you have an *extreme* fear of the dentist or dental treatment? Yes No

INSURANCE INFORMATION

Name of Subscriber _____ Subscriber's Social Security # _____
 Subscriber's Date of Birth _____ Relationship to Patient _____
 Name of Carrier _____ Phone # _____ Group # _____
 Is Patient covered by additional insurance? Yes No **If 'Yes', please fill out the following information...**
 Secondary Carrier _____ Phone # _____ Group # _____
 Name of Subscriber _____ Subscriber's Social Security # _____
 Subscriber's Date of Birth _____ Relationship to Patient _____
 I authorize payment of my insurance benefit directly to my dentist. _____ Patient Signature _____

HEALTH & DENTAL HISTORY

Place a mark on 'yes' to indicate if you have had any of the following...

<input type="checkbox"/> No <input type="checkbox"/> YES ANEMIA	<input type="checkbox"/> No <input type="checkbox"/> YES HIV	<input type="checkbox"/> No <input type="checkbox"/> YES BLEEDING GUMS
<input type="checkbox"/> No <input type="checkbox"/> YES ARTHRITIS	<input type="checkbox"/> No <input type="checkbox"/> YES KIDNEY DISEASE	<input type="checkbox"/> No <input type="checkbox"/> YES CLICKING/POPPING OF GUMS
<input type="checkbox"/> No <input type="checkbox"/> YES ARTIFICIAL JOINTS	<input type="checkbox"/> No <input type="checkbox"/> YES LIVER DISEASE	<input type="checkbox"/> No <input type="checkbox"/> YES JAW PAIN/TENDERNESS
<input type="checkbox"/> No <input type="checkbox"/> YES ASTHMA	<input type="checkbox"/> No <input type="checkbox"/> YES MENTAL DISORDERS	<input type="checkbox"/> No <input type="checkbox"/> YES FACIAL JOINT PAIN
<input type="checkbox"/> No <input type="checkbox"/> YES BLOOD DISEASE	<input type="checkbox"/> No <input type="checkbox"/> YES NERVOUS DISORDERS	<input type="checkbox"/> No <input type="checkbox"/> YES EAR PAIN
<input type="checkbox"/> No <input type="checkbox"/> YES CANCER	<input type="checkbox"/> No <input type="checkbox"/> YES PACEMAKER	<input type="checkbox"/> No <input type="checkbox"/> YES GRINDING TEETH
<input type="checkbox"/> No <input type="checkbox"/> YES DIABETES	<input type="checkbox"/> No <input type="checkbox"/> YES RESPIRATORY PROBLEM	<input type="checkbox"/> No <input type="checkbox"/> YES SENSITIVITY TO COLD
<input type="checkbox"/> No <input type="checkbox"/> YES DIZZINESS	<input type="checkbox"/> No <input type="checkbox"/> YES RHEUMATIC FEVER	<input type="checkbox"/> No <input type="checkbox"/> YES SENSITIVITY TO HOT
<input type="checkbox"/> No <input type="checkbox"/> YES EPILEPSY	<input type="checkbox"/> No <input type="checkbox"/> YES RHEUMATISM	<input type="checkbox"/> No <input type="checkbox"/> YES SENSITIVITY TO SWEETS
<input type="checkbox"/> No <input type="checkbox"/> YES PROLONGED BLEEDING	<input type="checkbox"/> No <input type="checkbox"/> YES SEIZURES	<input type="checkbox"/> No <input type="checkbox"/> YES PAIN WHEN BITING
<input type="checkbox"/> No <input type="checkbox"/> YES FAINTING	<input type="checkbox"/> No <input type="checkbox"/> YES SINUS PROBLEMS	<input type="checkbox"/> No <input type="checkbox"/> YES DO YOU SMOKE?
<input type="checkbox"/> No <input type="checkbox"/> YES GLAUCOMA	<input type="checkbox"/> No <input type="checkbox"/> YES STOMACH PROBLEMS	<input type="checkbox"/> No <input type="checkbox"/> YES DO YOU SNORE?
<input type="checkbox"/> No <input type="checkbox"/> YES HAY FEVER	<input type="checkbox"/> No <input type="checkbox"/> YES STROKE	<input type="checkbox"/> No <input type="checkbox"/> YES I am or maybe pregnant?
<input type="checkbox"/> No <input type="checkbox"/> YES HEART AILMENT	<input type="checkbox"/> No <input type="checkbox"/> YES TOURRETS	HAVE YOU HAD TEETH REMOVED? <input type="checkbox"/> No <input type="checkbox"/> YES
<input type="checkbox"/> No <input type="checkbox"/> YES HEART MURMUR	<input type="checkbox"/> No <input type="checkbox"/> YES TUBERCULOSIS	If "yes" date of removal _____
<input type="checkbox"/> No <input type="checkbox"/> YES HEPATITIS A,B, or C	<input type="checkbox"/> No <input type="checkbox"/> YES TUMORS	Last dental appointment was _____
<input type="checkbox"/> No <input type="checkbox"/> YES HIGH BLOOD PRESSURE	<input type="checkbox"/> No <input type="checkbox"/> YES VENEREAL DISEASE	
<input type="checkbox"/> No <input type="checkbox"/> YES ALLERGY TO LATEX /SPECIFIC DRUGS	If 'yes', please list all drug allergies... _____	

Have you had surgery? YES NO If 'yes', please specify _____
 Please list any additional health conditions: _____
 Please list all medications you are taking: _____
 Reason for today's visit _____

CONSENT

I give consent for x-rays and minor dental treatment for myself or child if patient is a minor.

Signed _____ Date _____