





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

Name						Soc. Sec. #	
	Last Name	Fi	rst Name	In	itial		
Address							
City			State	Zip		Home Phone	
Cell Phone			Email				
Sex □ M □ F Age		Birthdate_		□ Single	☐ Married ☐	☐ Widowed ☐ Separated ☐ Divorced	
Patient Employed by_						Occupation	
Business Address						Business Phone	-ÿ
Business Email						,	
Whom may we thank	for referring you? _						
Notify in case of emer	gency			Home Pho	one		
Cell Phone				Business	Phone		
Email							
			De	imary Insura	nce		
				illai y ilistira	nce		
Person Responsible fo	or Account		T. A.M.			Circat Marris	Initial
			Last Name			First Name	Initial
Relation to Patient			Birthdate			Soc. Sec. #	
Address (if different fr	rom patient)					Home Phone	
City				State		Zip	
Cell Phone						Email	
Person Responsible E	mployed by					Occupation	
Business Address		lg.				Business Phone	
Business Email	*						
Insurance Company _						Phone	
Insurance Email							
-						Subscriber #	
Name of other depend			-				
Name of outer depend	ieno under uno pian	· ,					
			Ado	litional Insur	ance		
Is patient covered by a	additional insurance) □ Yes	□ No				
Subscriber Name				Patient		Birthdate	
						#	
•						Home Phone	
						Email	
						Business Phone	
Business Email							
Insurance Company _						Phone	
Insurance Email							
Contract #			Group #			Subscriber #	
Name of other depend	lents under this plan						

Please complete both sides.





Dental History

What would you like us to do today?_		Are you in dental discomfort toda	ıy?							
Dentist's Email Phone Date of last dental care Date of last x-rays										
Check (✓) yes or no if you have had problems with any of the following: □ Y □ N Bad breath □ Y □ N Food collection between teeth □ Y □ N Periodontal treatment □ Y □ N Sensitivity to sweets										
☐ Y ☐ N Bleeding gums	☐ Y ☐ N Grinding or clenching teeth	☐ Y ☐ N Sensitivity to cold	☐ Y ☐ N Sensitivity when biting							
☐ Y ☐ N Clicking or popping jaw	☐ Y ☐ N Loose teeth or broken fillings	☐ Y ☐ N Sensitivity to hot	☐ Y ☐ N Sores or growths in mouth							
How often do you brush?		Floss?								
-	ce of your teeth?									
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? \(\sigma\) Y \(\sigma\) N										
Other information about your dental health or previous treatment										
Medical History										
Physician's name										
Physician's name Phone Date of last visit Have you had any serious illnesses or operations? □ Y □ N										
If yes, describe										
	re? \(\text{Y} \) \(\text{N} \) If yes, describe									
Have you ever had a blood transfusion		ite dates								
Have you ever taken Fen-Phen/Redux										
±/.	e medication? Brand names include Fosar	nax, Actonel, Atelvia, Didronel and Boni	va. 🗆 Y 🗖 N							
Women: Are you pregnant? □ Y □		rth control pills? □ Y □ N								
Check (✓) yes or no whether you h		•								
☐ Y ☐ N AIDS/HIV Positive	☐ Y ☐ N Cough, persistent	☐ Y ☐ N Jaw pain	☐ Y ☐ N Shingles							
☐ Y ☐ N Anaphylaxis	☐ Y ☐ N Cough up blood	☐ Y ☐ N Kidney disease or	☐ Y ☐ N Shortness of breath							
☐ Y ☐ N Anemia	☐ Y ☐ N Diabetes	malfunction	☐ Y ☐ N Skin rash							
☐ Y ☐ N Arthritis, Rheumatism	☐ Y ☐ N Epilepsy	☐ Y ☐ N Liver disease ☐ Y ☐ N Material allergies	☐ Y ☐ N Spina Bifida							
☐ Y ☐ N Artificial heart valves	Y N Fainting	(latex, wool, metal,	□ Y □ N Stroke							
☐ Y ☐ N Artificial joints ☐ Y ☐ N Asthma	☐ Y ☐ N Food allergies ☐ Y ☐ N Glaucoma	chemicals)	☐ Y ☐ N Surgical implant ☐ Y ☐ N Swelling of feet							
☐ Y ☐ N Atopic (allergy prone)	□ Y □ N Headaches	☐ Y ☐ N Mitral valve prolapse	or ankles							
☐ Y ☐ N Back problems	□ Y □ N Heart murmur	☐ Y ☐ N Nervous problems ☐ Y ☐ N Pacemaker/	☐ Y ☐ N Thyroid disease or							
☐ Y ☐ N Blood disease	☐ Y ☐ N Heart problems	Heart surgery	malfunction							
☐ Y ☐ N Cancer	Describe	 □ Y □ N Psychiatric care 	☐ Y ☐ N Tobacco habit ☐ Y ☐ N Tonsillitis							
☐ Y ☐ N Chemical dependency	☐ Y ☐ N Hemophilia/ Abnormal bleeding	☐ Y ☐ N Rapid weight gain or loss	□ Y □ N Tuberculosis							
☐ Y ☐ N Chemotherapy	□ Y □ N Herpes	☐ Y ☐ N Radiation treatment	☐ Y ☐ N Ulcer/Colitis							
☐ Y ☐ N Circulatory problems ☐ Y ☐ N Cortisone treatments	☐ Y ☐ N Hepatitis	☐ Y ☐ N Respiratory disease ☐ Y ☐ N Rheumatic/Scarlet fever	☐ Y ☐ N Venereal disease							
	\square Y \square N High blood pressure									
Is patient currently taking any medications? If yes, list all: Does patient have drug allergies? If yes, list all:										
	Auth	orization								
	Auti	Orization								
			t this information will be used by the dentist							
to help determine appropriate and he	althful dental treatment. If there is any cl	hange in my medical status, I will inform	the dentist.							
I authorize the insurance company I authorize the use of this signature or		dentist all insurance benefits otherw	rise payable to me for services rendered.							
I authorize the dentist to release all whether or not paid by insurance.	information necessary to secure the p	ayment of benefits. I understand that I	I am financially responsible for all charges							
Signature			e							
o .	yment is due in full at time of treatment,									
Pa B : R : I R	yment is due in full at time of treatment,	unicos prior arrangements nave been ap	proveu.							

 ${}^{\textstyle \bigcirc}\mathbf{S}\mathbf{martPractice}^{\textstyle \textcircled{\$}} \; \mathbf{All} \; \mathbf{rights} \; \mathbf{reserved}.$

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