WELCOME

We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

Patient Information

Name _____ _____ _____ Sex _____ Marital Status _____
Last First Middle

Address _____ _____ _____ _____
Street City State Zip

Birthdate _____ E-mail _____ Social Security# _____

Home Phone _____ Cell Phone _____ Work Phone _____ ext. _____

Employer _____ Occupation _____ No. Years Employed _____

General Dentist _____ Last Visited _____

Who may we thank for referring you to our office _____

Spouse / Additional Contact Information

Name _____ _____ _____ Marital Status _____
Last First Middle

Address _____ _____ _____ _____
Street City State Zip

Birthdate _____ E-mail _____ Relationship to Patient _____

Home Phone _____ Cell Phone _____ Work Phone _____ ext. _____

Employer _____ Occupation _____ No. Years Employed _____

Dental Insurance Information

Policy Owner's Name _____ Policy Owner's Social Security # _____

Policy Owner's Birthdate _____ Relationship to Patient _____

Policy Owner's Employer _____ Policy Group Num. _____

Insurance Company _____ Subscriber ID# _____

Insurance Co. Address _____ Insurance Phone No. _____

Do you have dual insurance coverage? ☐ Yes ☐ No

Medical History

Are you under the care of a physician? ☐ Yes ☐ No If Yes, explain _____

Physician _____ Phone _____ Last Visit _____

Address _____

Are you pregnant ☐ Yes ☐ No If so how many weeks _____

When and for what have you been hospitalized? _____

Have your tonsils or adenoids been removed? ☐ Yes ☐ No

Have you ever experienced jaw joint pain/ discomfort (TMJ/TMD)? ☐ Yes ☐ No

Do you have any congenitally missing or extra permanent teeth? ☐ Yes ☐ No

Have you ever had an injury to : (select all that apply) ☐ Teeth ☐ Mouth ☐ Chin

Do you have speech problems? ☐ Yes ☐ No if Yes, explain _____

Do your gums bleed? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No Do you like your smile? ☐ Yes ☐ No

Do your or have you ever had any of the following habits?

☐ Lip Sucking/Biting ☐ Nail biting ☐ Prolonged Bottle/Pacifier

☐ Clenching/Grinding Teeth ☐ Mouth Breather ☐ Tongue Thrusting ☐ Thumb/Finger Sucking

Are you allergic to any of the following?

☐ Aspirin ☐ Erythromycin

☐ Codeine ☐ Penicillin

☐ Tetracycline ☐ Latex

☐ Any Metals/Plastics

Other Allergies/Sensitivites:

_____

What medication do you take?

What illnesses do you have?

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidences and it is my responsibility to inform this office of any changes in my medical status.

I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.

I understand that where appropriate, credit bureau reports may be obtained.

Name of person filling out this form _____ Date _____