



### Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
Last, First MI (Preferred Name)

Gender: \_\_\_\_\_ Family Status: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Preferred appointment times:  Morning  Afternoon  Evening  Any Time  M  T  W  T  F  S

Address: \_\_\_\_\_  
Street Apartment #  
City State Zip Code

### Health Information

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

**Have you ever had any of the following? Please check those that apply:**

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> AIDS                | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Nervous Disorders    | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Allergies           | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Tumors             |
| <input type="checkbox"/> Angina (Chest Pain) | <input type="checkbox"/> Growths              | <input type="checkbox"/> Pregnancy            | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Hay Fever            | Due date: _____                               | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Head Injuries        | <input type="checkbox"/> Radiation Treatment  | <input type="checkbox"/> Codeine Allergy    |
| <input type="checkbox"/> Artificial Joints   | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Latex Allergy      |
| <input type="checkbox"/> Blood Disease       | <input type="checkbox"/> Hepatitis A, B, or C | <input type="checkbox"/> Rheumatism           | <input type="checkbox"/> Treatment for      |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Sinus Problems       | Osteoporosis/Paget's                        |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Jaundice             | <input type="checkbox"/> Stomach Problems     | Disease?                                    |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Stroke               | <input type="checkbox"/> OTHER:             |
| <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Tobacco              |   |
| <input type="checkbox"/> Excessive Bleeding  | <input type="checkbox"/> Mental Disorders     | <input type="checkbox"/> Thyroid Disease      |   |

- Are you currently experiencing dental pain or discomfort?  Yes  No
- Do you wear dentures or partials?  Yes  No
- Have you ever had any complications following dental treatment?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Have you ever had periodontal (gum) treatment?  Yes  No
- Do you grind (brux) your teeth?  Yes  No
- Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Are you now under the care of a physician?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_
- Do you have any health problems that need further clarification?  Yes  No  
If yes, please explain: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian \_\_\_\_\_ Date: \_\_\_\_\_



### Spouse or Responsible Party Information

The following is for:  the patient's spouse  the person responsible for payment

Name: \_\_\_\_\_  
 Male  Female  Married  Single  Child  Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #  
\_\_\_\_\_  
City State Zip Code

### Information

The following is for:  the patient  the person responsible for payment

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City, State Zip Code Phone

### Employment

### Insurance Information

Please fill out if Primary holder of the insurance is NOT the patient.

Name of Insured: \_\_\_\_\_  
Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street City State Zip Code

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_ Phone \_\_\_\_\_

#### Secondary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Last First MI

Insured's Address: \_\_\_\_\_  
Street City State Zip Code

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_ Phone \_\_\_\_\_

### Referral Information

Whom may we thank for referring you to our practice?  Another patient, friend  Little People's World

Yellow Pages  Newspaper  School  Direct Mail  Other \_\_\_\_\_

Name of person or office referring you to our practice: \_\_\_\_\_

### Consent for Services

I grant permission to you or your assignee, to telephone me at home or at work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

\_\_\_\_\_  
Signature of patient, parent or guardian Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Signature of guarantor of payment/responsible party Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_