New Patient Information:

Date ______ Home Phone ______ Cell Phone ______

Name ______

Address ______

City ______ State ______ Zip ______

Email ______

Sex: Male Female Age ______ Birthdate ______ Single Married Widowed Divorced Separated

Occupation ______ Employer ______ Work Phone ______

Whom may we thank you for referring you? ______

Whom may we notify in case of an emergency? ______ Phone ______

Insurance:

Primary

Who is responsible for this account? ______

Insurance Company ______

Subscriber/Member ID# ______ Group# ______ Group Name ______

Name of Subscriber on Primary Insurance ______

Subscriber's Birthdate ______ Subscriber's Social Security # ______

Address (if different from patient's) ______ Phone ______

City ______ State ______ Zip Code ______

Employed By ______ Occupation ______

Name of other dependents covered by this plan ______

Secondary

Is patient covered by additional insurance? Yes ☐ No ☐

Insurance Company ______

Subscriber/Member ID# ______ Group# ______ Group Name ______

Name of Subscriber on Secondary Insurance ______

Subscriber's Birthdate ______ Subscriber's Social Security # ______

Address (if different from patient's) ______ Phone ______

City ______ State ______ Zip Code ______

Employed By ______ Occupation ______

Name of other dependents covered by this plan ______

Dental Health History:

Reason for today's visit ______

Previous Dentist ______ Phone# ______

Address ______

Date of last dental care ______ Last dental x-rays ______

Please circle if you have had trouble with any of the following:

Bad Breath	Loose Teeth or Broken Fillings	Sensitivity when Biting
Bleeding Gums	Periodontal Treatment	Food Collection Between Teeth
Clicking or Popping Jaw	Sensitivity to Heat	Sensitivity to Cold
Grinding Teeth	Sensitivity to Sweets	Sores or Growths in your mouth

How often do you floss?________________ How often do you brush?________________

Medical History

Physician's Name________________ Date of last visit ________________

Previous hospitalizations, illnesses or operations (please describe and give approximate dates)________________

____

Have you ever had a blood transfusion? Yes ☐ No ☐ If yes, please give approximate date ________________

Women: Are you pregnant? Yes ☐ No ☐ Nursing? Yes ☐ No ☐ Taking Birth Control Pills? Yes ☐ No ☐

Please circle if you have had or have any of the following:

Aids	Cortisone Treatments	Hepatitis	Scarlet Fever
Anemia	Cough, Persistent	High Blood Pressure	Shortness of Breath
Arthritis, Rheumatism	Cough up Blood	HIV Positive	Skin Rash
Artificial Heart Valves	Diabetes	Jaw Pain	Stroke
Artificial Joints	Epilepsy	Kidney Disease	Swelling of feet/ankle
Asthma	Fainting	Mitral Valve Prolapse	Thyroid Problems
Back Problems	Glaucoma	Nervous Problems	Tobacco Habit
Blood Disease	Headaches	Pacemaker	Tonsillitis
Cancer	Heart Murmur	Psychiatric Care	Tuberculosis
Chemical Dependency	Heart Problems________	Radiation Treatment	Ulcer
Chemotherapy	Hemophilia	Venereal Disease	Osteoporosis
Circulatory Problems	Respiratory Disease	Rheumatic Fever	

Please list any medications you are currently taking ________________

Pleast list any allergies________________

Authorization

I have reviewed this questionnaire and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate treatment and I agree to notify the dentist if any changes in my health status occur.

I authorize the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize use of this signature on all insurance submissions.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

Signiture________________________ Date________________

<u>PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN PROVED</u>