

**PATIENT INFORMATION**

Name \_\_\_\_\_  
Last Name First Name Middle Initial

Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_

Sex:  M  F  Minor  Single  Married  Long Term Partner  Divorced  Widowed  Separated

Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Address \_\_\_\_\_ Occupation \_\_\_\_\_

**Family Members**

Spouse \_\_\_\_\_ Birthdate \_\_\_\_\_

**Other**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship \_\_\_\_\_

In case of emergency, who should we contact? \_\_\_\_\_ Phone \_\_\_\_\_

**PRIMARY DENTAL INSURANCE**

Person Responsible for Account \_\_\_\_\_  
Last Name First Name Initial

Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_

Responsible Party Employed By \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Address \_\_\_\_\_ Occupation \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Subscriber I.D.# \_\_\_\_\_ Group # \_\_\_\_\_

**ADDITIONAL INSURANCE**

Insured Name \_\_\_\_\_  
Last Name First Name Initial

Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_

Insured Employed By \_\_\_\_\_ Business Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Subscriber I.D.# \_\_\_\_\_ Group # \_\_\_\_\_

## DENTAL HISTORY

Former Dentist \_\_\_\_\_ Date of Last X-Rays \_\_\_\_\_  
 City, State \_\_\_\_\_ How Often Do You Floss? \_\_\_\_\_  
 Date of Last Dental Visit? \_\_\_\_\_ How Often Do You Brush? \_\_\_\_\_  
 Any Dental Problems - List: \_\_\_\_\_

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Dr. Phone Number \_\_\_\_\_

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1. Are you currently under medical treatment? .....             | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had any serious illnesses or operations? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Please list: _____  |                          |                          |
| 3. Are you currently taking any medication? .....               | <input type="checkbox"/> | <input type="checkbox"/> |
| Please list: _____  |                          |                          |
| 4. Do you smoke? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use alcohol? .....                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you use cocaine or other drugs? .....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you had any allergic reactions to the following: .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Local Anesthetics (eg. novocaine) .....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa Drugs .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Other Antibiotics .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Any other known allergies .....                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. (Women Only) Are You: .....                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Pregnant? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Nursing? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Taking Birth Control Pills? .....                               | <input type="checkbox"/> | <input type="checkbox"/> |

**PLEASE CHECK ALL THAT APPLY:**

- |   |                          |                             |                          |                                    |                          |
|---|--------------------------|-----------------------------|--------------------------|------------------------------------|--------------------------|
| AIDS .....  | <input type="checkbox"/> | Emphysema .....             | <input type="checkbox"/> | Nervous Problems .....             | <input type="checkbox"/> |
| Anemia .....  | <input type="checkbox"/> | Epilepsy .....              | <input type="checkbox"/> | Pacemaker .....                    | <input type="checkbox"/> |
| Arthritis, Rheumatism .....                               | <input type="checkbox"/> | Fainting or Dizziness ..... | <input type="checkbox"/> | Psychiatric Care .....             | <input type="checkbox"/> |
| Artificial Heart Valves .....                             | <input type="checkbox"/> | Headaches .....             | <input type="checkbox"/> | Radiation Treatment .....          | <input type="checkbox"/> |
| Artificial Joints .....                                   | <input type="checkbox"/> | Heart Murmur .....          | <input type="checkbox"/> | Respiratory Disease .....          | <input type="checkbox"/> |
| Asthma .....  | <input type="checkbox"/> | Heart Problems .....        | <input type="checkbox"/> | Rheumatic Fever .....              | <input type="checkbox"/> |
| Bleeding abnormally, with<br>extractions or surgery ..... | <input type="checkbox"/> | Hepatitis-Type _____ .....  | <input type="checkbox"/> | Scarlet Fever .....                | <input type="checkbox"/> |
| Blood Disease .....                                       | <input type="checkbox"/> | Herpes .....                | <input type="checkbox"/> | Shortness of Breath .....          | <input type="checkbox"/> |
| Cancer .....  | <input type="checkbox"/> | High Blood Pressure .....   | <input type="checkbox"/> | Sinus Trouble .....                | <input type="checkbox"/> |
| Chemical Dependency .....                                 | <input type="checkbox"/> | HIV Positive .....          | <input type="checkbox"/> | Skin Rash .....                    | <input type="checkbox"/> |
| Chemotherapy .....  | <input type="checkbox"/> | Jaundice .....              | <input type="checkbox"/> | Stroke .....                       | <input type="checkbox"/> |
| Circulatory Problems .....                                | <input type="checkbox"/> | Jaw Pain .....              | <input type="checkbox"/> | Swelling of Feet/Ankles .....      | <input type="checkbox"/> |
| Congenital Heart Lesions .....                            | <input type="checkbox"/> | Kidney Disease .....        | <input type="checkbox"/> | Swollen Neck Glands .....          | <input type="checkbox"/> |
| Cortisone Treatments .....                                | <input type="checkbox"/> | Latex Sensitivity .....     | <input type="checkbox"/> | Tonsillitis .....                  | <input type="checkbox"/> |
| Diabetes .....  | <input type="checkbox"/> | Liver Disease .....         | <input type="checkbox"/> | Tuberculosis .....                 | <input type="checkbox"/> |
|   |                          | Low Blood Pressure .....    | <input type="checkbox"/> | Tumor or growth on head/neck ..... | <input type="checkbox"/> |
|   |                          | Mitral Valve Prolapse ..... | <input type="checkbox"/> | Venereal Disease .....             | <input type="checkbox"/> |

## ASSIGNMENT AND RELEASE

I hereby authorize payment directly to \_\_\_\_\_ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_