Welcome

Please fill out front & back sides of this questionnaire.

About You

Name: ______________________________ Insured SS#__________________ Sex: _________

D.O.B.:______________ Age: _____ Marital Status: __________ Cell # ____________________

Email ________________________ Text Messages OK? ☐ Yes ☐ No (check one)

Home # ________________ Work # __________________ Pharmacy #___________________

Street Address: _________________________________ City, State, Zip ____________________

Employer: ____

Emergency Contact

Name: ______________________ Phone#_______________________

1. Spouse Information

His/Her Name: ________________________ SS#_____________________D.O.B: __________

Employer: ____ Work # ___________________

2. Dental Concerns

What is the reason for today's visit?____

Do you have any questions/concerns about any other teeth? ______________________________

How many times a day do you brush?_________ Floss? _______

Do you use tobacco products? ___________

Why did you leave your last Dentist? ____

When was your last dental visit? ____

Whom may we thank for referring you? ____

3. Payment Options - check one (To include Insurance Deductibles and Co-Payments)

☐ No interest monthly payment plan (with credit check)

☐ Credit Card: ☐ Visa ☐ MC ☐ Discover ☐ American Express _______

☐ Cash or Check _________________________________

(OVER)

4. Medical History

Check any of the following you have had or suspected.

- ☐ Anemia / Radiation Treatment
- ☐ Artificial Bones / Joints
- ☐ Epilepsy / Seizures / Fainting Spells
- ☐ Asthma / Arthritis
- ☐ Blood Transfusion
- ☐ Cancer / Chemotherapy
- ☐ Congenial Heart Defect
- ☐ Hemophilia / Abnormal Bleeding
- ☐ Difficulty Breathing
- ☐ Drug / Alcohol Abuse
- ☐ Emphysema / Glaucome
- ☐ Fever Blistes / Herpes
- ☐ Artificial Valves
- ☐ Heart Attacks / Strokes
- ☐ Heart Murmur
- ☐ Heart Surgery / Pacemaker
- ☐ Hepatitis A B C
- ☐ Diabetes / Tuberculosis
- ☐ Ulcer / Colitis
- ☐ HIV+ / AIDS
- ☐ Hospitalized for any Reason
- ☐ Kidney Problems
- ☐ Mitral Valve Prolapse
- ☐ Psychiatric Problems
- ☐ Rheumatic / Scarlet Fever
- ☐ Severe / Frequent Headache
- ☐ Shingles
- ☐ Sinus Problems
- ☐ High / Low Blood Pressure
- ☐ Venereal Disease

Are you on blood thinners?: ☐ YES ☐ NO

Please list all medications / vitamins you are taking: ____________________________________

____

____

Check off any of the following you may be allergic to :

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Latex
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Lead or Metal Alloys
- ☐ Other ______________

Are you under the care of a physician: ☐ YES ☐ NO

If yes, please explain ____

____

Female patients, are you pregnant?: ☐ YES ☐ NO

If yes, expected due date ____

(OVER)

5. Insurance Info

Primary Dental Insurance

Co. Name: ________________________________ Phone #: _____________________________

Address: _________________________________ City, State, Zip _________________________

Insured's ID #: ________________________ Group # (Plan, Local, or Policy #): ___________________

Insured's Name: ___________________________Relation: ____________ D.O.B: ___________

Insured's Employer: ____

Secondary Dental Insurance

Co. Name: ________________________________ Phone #: _____________________________

Address: _________________________________ City, State, Zip _________________________

Insured's ID #: ________________________ Group # (Plan, Local, or Policy #): ___________________

Insured's Name: ___________________________Relation: ____________ D.O.B: ___________

Insured's Employer: ____

I authorize and give consent to perform dental services agreed upon between doctor and patient and/or parent or guardian to be necessary of advisable treatments including the use of local anesthesia and other medications as indicated. I certify to the above statements regarding my medical condition. I also understand that it is my responsibility to inform this office of any changes in my medical status.

Patient's Signature ___________________________________ Date: ______________________

Parent or guardian ___________________________________ Date: ______________________

(If patient is child or requires a guardian)