

# Welcome

Please fill out front & back sides of this questionnaire.



## About You

Name: \_\_\_\_\_ 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.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Anemia / Radiation Treatment          | <input type="checkbox"/> Emphysema / Glaucoma      | <input type="checkbox"/> Hospitalized for any Reason |
| <input type="checkbox"/> Artificial Bones / Joints             | <input type="checkbox"/> Fever Blisters / Herpes   | <input type="checkbox"/> Kidney Problems             |
| <input type="checkbox"/> Epilepsy / Seizures / Fainting Spells | <input type="checkbox"/> Artificial Valves         | <input type="checkbox"/> Mitral Valve Prolapse       |
| <input type="checkbox"/> Asthma / Arthritis                    | <input type="checkbox"/> Heart Attacks / Strokes   | <input type="checkbox"/> Psychiatric Problems        |
| <input type="checkbox"/> Blood Transfusion                     | <input type="checkbox"/> Heart Murmur              | <input type="checkbox"/> Rheumatic / Scarlet Fever   |
| <input type="checkbox"/> Cancer / Chemotherapy                 | <input type="checkbox"/> Heart Surgery / Pacemaker | <input type="checkbox"/> Severe / Frequent Headache  |
| <input type="checkbox"/> Congenital Heart Defect               | <input type="checkbox"/> Hepatitis A B C           | <input type="checkbox"/> Shingles                    |
| <input type="checkbox"/> Hemophilia / Abnormal Bleeding        | <input type="checkbox"/> Diabetes / Tuberculosis   | <input type="checkbox"/> Sinus Problems              |
| <input type="checkbox"/> Difficulty Breathing                  | <input type="checkbox"/> Ulcer / Colitis           | <input type="checkbox"/> High / Low Blood Pressure   |
| <input type="checkbox"/> Drug / Alcohol Abuse                  | <input type="checkbox"/> HIV+ / AIDS               | <input type="checkbox"/> 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 :

- |   |                                       |   |
|---|---------------------------------------|---|
| <input type="checkbox"/> Aspirin            | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Tetracycline         |
| <input type="checkbox"/> Codeine            | <input type="checkbox"/> Latex        | <input type="checkbox"/> Lead or Metal Alloys |
| <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Penicillin   | <input type="checkbox"/> 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: \_\_\_\_\_

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I authorize and give consent to perform dental services agree between doctor and patient and/or parent or guardian to be necessary of advisable 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)