



Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Midress Gity	Name			Soc. Sec. #	
State	Last Name	First Name	Initial		
State	Address				
Patient Employed by			Zip	Home Phone	
Patient Employed by	Cell Phone	Email			
Business Address Business Phone Business Phone Business Email Business Email Business Email Business Email Business Phone Bu	Sex D M D F Age Birthdate		□ Single □ Marrie	ed 🗆 Widowed 🗅 Separated 🗀 Divorced	
Business Email Whom ray we thank for referring you? Notify in case of emergency Home Phone Cell Phone Business Phone Email Primary Insurance Person Responsible for Account Last Name First Name Institut Relation to Patient Birthdate Soc. Sec. # Institut Relation to Patient Birthdate Soc. Sec. # Insurance City State Zip Cell Phone Email Person Responsible Employed by Occupation Business Address (If different from patient) Business Phone Business Address Group # Subscriber # Namance Company Phone Pharmacy Phone Pharmacy Phone Business Address Subscriber # Subscriber for Account Business Phone Business Address Subscriber # Business Address Business Phone Business Email Business Phone Business Phone Business Email Business Phone Business P	Patient Employed by			Occupation	
Notify in case of emergency Business Phone Email Person Responsible for Account Last Name Birthdate Soc. Sec. # Address (if different from patient) Business Address Business Email Person Responsible Employed by Gocupation Business Email Business Address Business Address Business Email Business Address Business Address Business Address Business Email	Business Address			Business Phone	
Notify in case of emergency Business Phone Email Person Responsible for Account Last Name Last Name Burindate Soc. Sec. #	Business Email				
Email Person Responsible for Account Last Name Birthdate Relation to Patient from patient) Birthdate Soc. Sec. # Address (if different from patient) Birthdate State Zip Cell Phone Business Phone Business Phone Business Phone Susiness Address First Name Address Address First Name Home Phone Caty State Zip Cell Phone Business Phone Business Phone Business Phone Susiness Address First Name Address Address Address Brail Ferson Responsible Employed by Business Phone Business Phone Susiness Phone Additional Insurance Soc. Sec. # Subscriber # Subscriber # Subscriber Address Subscriber # Subscriber Address Subscriber Rame Address (if different from patient) Soc. Sec. # Subscriber Name Address (if different from patient) Soc. Sec. # Subscriber Phone Soc. Sec. # Subscriber Phone Birthdate Address (if different from patient) Soc. Sec. # Subscriber Phone Business Phone Business Phone					
Primary Insurance Primary Insurance Priss Name Initial I					
Person Responsible for Account Last Name Birthdate Soc. Sec. # Address (if different from patient) City Cell Phone Business Address Business Phone Business Email Insurance Company Insurance Address Cortract # Group # Subscriber # Name Phone Sate Additional Insurance Ferson Responsible insurance? Yes No Subscriber Name Relation to Patient Soc. Sec. # Additional Insurance First Name Phone Business Phone Business Final Final Additional Insurance Final Birthdate Birthdate Final Birthdate Final Fina	Cell Phone		Business Phone		
Relation to Patient	Email				
Relation to Patient Birthdate Soc. Sec. # Address (if different from patient) Birthdate Zip Cocupation State Zip Cocupation Business Address Business Phone Business Address Business Phone Business Address Business Phone Business Address Business Phone Business Business Phone Business Email		Pri	mary Insurance		
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Address (if different from patient) City State Zip Email Person Responsible Employed by Occupation Business Address Business Phone Business Email Insurance Company Phone Insurance Address Contract # Group # Subscriber # Name of other dependents under this plan Pharmacy Phone Is patient covered by additional insurance? Yes No Subscriber Ame Relation to Patient Birthdate Address (if different from patient) Soc. Sec. # City State Zip Home Phone Cell Phone Business Phone Business Phone Business Phone Insurance Company Phone Phone Phone Address (if different from patient) Phone Cell Phone Phone Business Phone Business Phone Business Phone Business Phone Business Phone Phone Phone Business Phone Business Phone Business Phone		Last Name		First Name	Initial
Gity	Relation to Patient	Birthdate		Soc. Sec. #	
Cell Phone	Address (if different from patient)			Home Phone	
Cell Phone	City		State	Zip	
Business Address Business Phone Business Email Phone Insurance Company Phone Insurance Address Subscriber # Subscriber # Phone Additional Insurance Is patient covered by additional insurance? Yes No Subscriber Name Relation to Patient Birthdate Address (if different from patient) Soc. Sec. # Size Zip Home Phone Cell Phone Email Subscriber Employed by Business Phone Business Email Insurance Company Phone Insurance Company Phone Business Email					
Business Email	Person Responsible Employed by	Occupation_			
Business Email	Business Address				
Insurance Company Phone					
Contract # _ Group # _ Subscriber # _ Name of other dependents under this plan Phone Phone Additional Insurance Is patient covered by additional insurance?					
Contract # _ Group # _ Subscriber # _ Name of other dependents under this plan Phone Phone Additional Insurance Is patient covered by additional insurance?	Insurance Address				
Name of other dependents under this plan					
Pharmacy					
Is patient covered by additional insurance?					
Is patient covered by additional insurance?	,				
Subscriber Name Relation to Patient Soc. Sec. # City State Zip Home Phone Cell Phone Email_ Subscriber Employed by Business Phone Insurance Company Phone Insurance Email		Add	litional Insurance		
Subscriber Name Relation to Patient Soc. Sec. # City State Zip Home Phone Cell Phone Email_ Subscriber Employed by Business Phone Insurance Company Phone Insurance Email	Is patient covered by additional insurance? ☐ Yes	i □ No		_	
Address (if different from patient)Soc. Sec. #			Patient	Birthdate	
City StateZip Home Phone Cell Phone Email Subscriber Employed by Business Phone Business Email Phone Insurance Company Phone					
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Subscriber Employed by Business Phone Business Email Phone Insurance Email					
Business Email Phone Insurance Email					
Insurance Company Phone Insurance Email					
Insurance Email					
	13 300 00 00 00 00 00 00 00 00 00 00 00 0				
Contract # Cyboniban #					
Contract # Group # Subscriber # Subscriber #		Group #		Subscriber #	

Please complete both sides.



What would you like us to do today?		Are you in dental discomfort to	Are you in dental discomfort today?		
	Address				
Dentist's Email	Phone				
	Date				
	and problems with any of the following:	,			
☐ Y ☐ N Bad breath	☐ Y ☐ N Food collection between teeth	☐ Y ☐ N Periodontal treatment	☐ Y ☐ N Sensitivity to sweets		
☐ Y ☐ N Bleeding gums	☐ Y ☐ N Grinding or clenching teeth	☐ Y ☐ N Sensitivity to cold	☐ Y ☐ N Sensitivity when biting		
☐ Y ☐ N Clicking or popping jaw			☐ Y ☐ N Sensitivity to hot ☐ Y ☐ N Sores or growths in mou		
How often do you brush?		3.55			
How do you feel about the appearan		- Colodocacoo Company			
100	ter? □ Y □ N Do you wish your	teeth were whiter?			
Are you unhappy with any fillings, cr					
	erse reaction during or in conjunction	with a medical or dental procedure?	DY DN		
	l health or previous treatment	-			
	ADDRESS OF THE PROPERTY OF THE	ical History			
Date of last visit	Have you had any seriou	s illnesses or operations? 🔲 Y 🔲 N			
f yes, describe					
Are you currently under physician ca	are? □ Y □ N If yes, describe				
Have you ever had a blood transfusion	on? ☐ Y ☐ N If yes, give approxim	nate dates			
Have you ever taken Fen-Phen/Redu	x?				
Have you ever used a bisphosphona	te medication? Brand names include Fos	amax, Actonel, Atelvia, Didronel and Bo	niva. 🗆 Y 🗀 N		
Do you smoke or use other tobacco.	/smokeless products? ☐ Y ☐ N Pleas	se circle all that apply: Cigarettes Cigar	rs Vape Marijuana Chew Other		
Women: Are you pregnant? 🔲 Y 🔾	□ N Nursing? □ Y □ N Taking l	oirth control pills? 🗆 Y 🗅 N			
Check (🗸) yes or no whether you	have had any of the following:				
☐ Y ☐ N AIDS/HIV Positive	☐ Y ☐ N Cough, persistent	☐ Y ☐ N Jaw pain	☐ Y ☐ N Shingles		
☐ Y ☐ N Anaphylaxis	☐ Y ☐ N Cough up blood	☐ Y ☐ N Kidney disease or	☐ Y ☐ N Shortness of breath		
Y N Anemia	☐ Y ☐ N Diabetes	malfunction ☐ Y ☐ N Liver disease	☐ Y ☐ N Skin rash		
☐ Y ☐ N Arthritis, Rheumatism ☐ Y ☐ N Artificial heart valves	□ Y □ N Epilepsy	☐ Y ☐ N Material allergies	☐ Y ☐ N Spina Bifida		
Y N Artificial joints	☐ Y ☐ N Fainting ☐ Y ☐ N Food allergies	(latex, wool, metal,	☐ Y ☐ N Stroke ☐ Y ☐ N Surgical implant		
□ Y □ N Asthma	☐ Y ☐ N Glaucoma	chemicals)	☐ Y ☐ N Swelling of feet		
☐ Y ☐ N Atopic (allergy prone)	☐ Y ☐ N Headaches	☐ Y ☐ N Mitral valve prolapse ☐ Y ☐ N Nervous problems	or ankles		
☐ Y ☐ N Back problems	☐ Y ☐ N Heart murmur	☐ Y ☐ N Pacemaker/	☐ Y ☐ N Thyroid disease or		
☐ Y ☐ N Blood disease	☐ Y ☐ N Heart problems	Heart surgery	malfunction ☐ Y ☐ N Tobacco habit		
Y N Cancer	Describe	— □ Y □ N Psychiatric care	☐ Y ☐ N Tonsillitis		
☐ Y ☐ N Chemical dependency ☐ Y ☐ N Chemotherapy	Abnormal bleeding	☐ Y ☐ N Rapid weight gain or loss	☐ Y ☐ N Tuberculosis		
Y N Circulatory problems	☐ Y ☐ N Herpes	□ Y □ N Radiation treatment□ Y □ N Respiratory disease	☐ Y ☐ N Ulcer/Colitis		
Y N Cortisone treatments	☐ Y ☐ N Hepatitis	☐ Y ☐ N Respiratory disease	☐ Y ☐ N Venereal disease		
	☐ Y ☐ N High blood pressure		una liat all.		
re you currently taking any medicati	ons: ii yes, iist aii:	Do you have any drug allergies? If	yes, list all:		
	Aut	horization			
have reviewed the information on t	his questionnaire, and it is accurate to the	e hest of my knowledge. Lunderstand th	hat this information will be used by the de		
	nealthful dental treatment. If there is any				
000 000 000	77 ANN 260 MAIN SO SO S S S S S S S S S S S S S S S S	001 0014 198 20 war M2 040	rwise payable to me for services rende		
authorize the insurance comparauthorize the use of this signature		e delition an insurance benefits offici	mise payable to file for services relide		
authorize the dentist to release a	dl information necessary to secure the	payment of benefits. I understand tha	t I am financially responsible for all cha		
and the time definition to refeate a	seems incessing to seeme the	r	Illimiterary responsible for all char		

whether or not paid by insurance.

Signature _

Payment is due in full at time of treatment, unless prior arrangements have been approved.