Welcome

We are pleased to welcome you and your child 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 your child.

Patient Information

Child's Name ______________________ Soc. Sec. # ______
Last Name First Name Initial

Address ______

City ______ State ______ Zip ______ Home Phone ______

Cell Phone ______ Email ______

Sex ❑ M ❑ F Age______ Birthdate ______ School ______ Grade ______

Hobbies/Sports ______

Whom may we thank for referring you? ______

Notify in case of emergency ______ Relation to Child ______

Home Phone ______ Cell Phone ______ Email ______

Primary Insurance

Person Responsible for Account ______________________
Last Name First Name Initial

Relation to Child ______ Birthdate ______ Soc. Sec. # ______

Address (if different from childs) ______ City ______ State ______ Zip ______

Home Phone ______ Cell Phone ______ Email ______

Person Responsible Employed by ______ Occupation ______

Business Address ______ Business Phone ______

Business Email ______

Insurance Company ______ Insurance Company Phone ______

Insurance Address ______

Contract # ______ Group # ______ Subscriber #

Name of other dependents under this plan ______

Pharmacy ______ Phone ______

Additional Insurance

Is child covered by additional insurance? ❑ Yes ❑ No

Subscriber Name ______ Relation to Child ______ Birthdate ______

Address (if different from child) ______ Soc. Sec. # ______

City ______ State ______ Zip ______ Home Phone ______

Cell Phone ______ Email ______

Subscriber Employed by ______ Business Phone ______

Business Email ______

Insurance Company ______ Insurance Company Phone ______

Insurance Address ______

Contract # ______ Group # ______ Subscriber # ______

Name of other dependents under this plan ______

Please complete both sides.

Dental History

What would you like us to do today? ______ Are you in dental discomfort today? ______

Former Dentist ______ Address ______

Dentist's Email ______ Phone ______

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

Check (3) yes or no if you have had 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 Loose Teeth or Broken Fillings	❑ Y ❑ N Sensitivity to Hot	❑ Y ❑ N Sores or Growths in mouth

How often do you brush? ______ Floss? ______

How do you feel about the appearance of your teeth? ______ Do you wish your teeth were straighter? ❑ Y ❑ N

Do you wish your teeth were whiter? ❑ Y ❑ N Are you unhappy with any fillings, crowns or bridges? ❑ Y ❑ N

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Other information about your dental health or previous treatment ______

Medical History

Physician's name ______ Phone ______

Date of last visit ______ Have you had any serious illnesses or operations? ❑ Y ❑ N

If yes, describe ______

Are you currently under physician care? ❑ Y ❑ N If yes, describe ______

Have you ever had a blood transfusion? ❑ Y ❑ N If yes, give approximate dates ______

Have you ever taken Fen-Phen/Redux? ❑ Y ❑ N

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ❑ Y ❑ N

Do you smoke or use other tobacco/smokeless products? ❑ Y ❑ N Please circle all that apply: Cigarettes Cigars Vape Marijuana Chew Other ______

Women: Are you pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking birth 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 Malfunction	❑ Y ❑ N Shortness of Breath
❑ Y ❑ N Anemia	❑ Y ❑ N Diabetes	❑ Y ❑ N Liver Disease	❑ Y ❑ N Skin Rash
❑ Y ❑ N Arthritis, Rheumatism	❑ Y ❑ N Epilepsy	❑ Y ❑ N Material Allergies (Latex, wool, metal, chemicals)	❑ Y ❑ N Spina Bifida
❑ Y ❑ N Artificial Heart Valves	❑ Y ❑ N Fainting	❑ Y ❑ N Mitral Valve Prolapse	❑ Y ❑ N Stroke
❑ Y ❑ N Artificial joints	❑ Y ❑ N Food Allergies	❑ Y ❑ N Nervous Problems	❑ Y ❑ N Surgical Implant
❑ Y ❑ N Asthma	❑ Y ❑ N Glaucoma	❑ Y ❑ N Pacemaker/ Heart Surgery	❑ Y ❑ N Swelling of Feet or Ankles
❑ Y ❑ N Atopic (allergy prone)	❑ Y ❑ N Headaches	❑ Y ❑ N Psychiatric Care	❑ Y ❑ N Thyroid Disease or Malfunction
❑ Y ❑ N Back Problems	❑ Y ❑ N Heart Murmur	❑ Y ❑ N Rapid Weight Gain or Loss	❑ Y ❑ N Tobacco Habit
❑ Y ❑ N Blood Disease	❑ Y ❑ N Heart Problems Describe ______	❑ Y ❑ N Radiation Treatment	❑ Y ❑ N Tonsillitis
❑ Y ❑ N Cancer	❑ Y ❑ N Hemophilia/ Abnormal Bleeding	❑ Y ❑ N Respiratory Disease	❑ Y ❑ N Tuberculosis
❑ Y ❑ N Chemical Dependency	❑ Y ❑ N Herpes	❑ Y ❑ N Rheumatic/Scarlet Fever	❑ Y ❑ N Ulcer/Colitis
❑ Y ❑ N Chemotherapy	❑ Y ❑ N Hepatitis		❑ Y ❑ N Venereal Disease
❑ Y ❑ N Circulatory Problems	❑ Y ❑ N High Blood Pressure		
❑ Y ❑ N Cortisone Treatments			

Are you currently taking any medications? If yes, list all: ______

Do you have any drug allergies? If yes, list all: ______

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ______ Date ______

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

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