



COSMETIC & FAMILY DENTISTRY

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Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to call us.

SS # _____

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Check appropriate box: Minor Single Married Divorced Widowed Separated

Patient's or parent's employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or parent's name _____ Employer _____ Work Phone _____

If patient is a student, name of school/college _____ City _____ State _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Relation to patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____

Employer _____ Work Phone _____

Is this person currently a patient in our office? Yes No

INSURANCE INFORMATION

Name of insured _____ Relation to patient _____

Birthdate _____ Social Security # _____ Date employed _____

Employer _____ Work Phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

ADDITIONAL INSURANCE

Name of insured _____ Relation to patient _____

Birthdate _____ Social Security # _____ Date employed _____

Employer _____ Work Phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____

Address _____

Date of last dental visit _____ Date of last dental x-rays _____

Check (✓) if you have had any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to heat |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between the teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's name _____ Date of last visit _____

Have you had serious illnesses or operations? Yes No If yes, describe _____

Have you had a blood transfusion? Yes No If yes, give approximate dates _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check (✓) if you have had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cortisone treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, persistent | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Arthritis, rheumatism | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> HIV positive | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Dental anxiety | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Swelling of feet or ankles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Auto immune | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mitral Valve prolapse | <input type="checkbox"/> Tobacco habit |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous problems | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Chemotherapy | Describe _____ | <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic fever | _____ |

MEDICATIONS

List medications you are currently taking:

ALLERGIES

List all allergies:

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor 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. I authorize the use of this signature on all insurance submissions.

Signature of patient or parent if minor

Date