

Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____
Last First MI Preferred Name

Title: _____ Gender: Male Female Family Status: Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: _____
SS#: _____
Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____
Home Mobile Work Ext Fax Other

Address: _____
Address 1 Address 2
City State Zip Code

The following is for: the patient the person responsible for payment both not applicable

Employer Name: _____ Phone: _____

Employer Address: _____
Address 1 Address 2
City State Zip Code

Whom may we thank for referring you to our practice?

In an emergency who should be notified? Please enter Name and Phone number below:

Signature _____ Date _____

Primary Dental Insurance:

Name of Insured: _____
Last First MI

Insured's Birth Date: _____

ID #: _____ Group #: _____

Insured's Address: _____
Address 1 Address 2
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____
Address 1 Address 2
City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name: _____

Insurance Address: _____
Address 1 Address 2
City State Zip Code

Insurance Authorization:

- By checking this box,
I authorize my insurance to pay my benefits directly to the dentist for all services rendered.
I authorize the use of this electronic 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 _____

Secondary Dental Insurance

Name of Insured: _____
Last First MI

Insured's Birth Date: _____

ID #: _____ Group #: _____

Insured's Address: _____
Address 1 Address 2

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____
Address 1 Address 2

City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name: _____

Insurance Address: _____
Address 1 Address 2

City State Zip Code

Insurance Authorization:

- By checking this box,
I authorize my insurance to pay my benefits directly to the dentist for all services rendered.
I authorize the use of this electronic 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.

Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> *Pre-Med - Amox | <input type="checkbox"/> *Pre-Med - Clind | <input type="checkbox"/> *Pre-Med - Other | <input type="checkbox"/> Allergic |
| <input type="checkbox"/> Allergice to Penicil | <input type="checkbox"/> Allergies | <input type="checkbox"/> Allergy - Aspirin | <input type="checkbox"/> Allergy - Codeine |
| <input type="checkbox"/> Allergy - Erythro | <input type="checkbox"/> Allergy - Hay Fever | <input type="checkbox"/> Allergy - Latex | <input type="checkbox"/> Allergy - Other |
| <input type="checkbox"/> Allergy - Penicillin | <input type="checkbox"/> Allergy - Sulfa | <input type="checkbox"/> Anemia | <input type="checkbox"/> Anti Depressants |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bisphosphonates |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Bug Bites | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Cats | <input type="checkbox"/> Colitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Herpes/Fever Blister | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Hospitalized | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Mitro Valve Prolapse |
| <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Other | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Seasonal | <input type="checkbox"/> Seizures | <input type="checkbox"/> shingles |
| <input type="checkbox"/> Sickel Cell Disease | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Skelton | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> SVT | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Tumors | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Zithromx |

- | | |
|---|--|
| <input type="checkbox"/> Ever been hospitalized (illness or injury) | <input type="checkbox"/> Presently being treated for any other illnesses |
| <input type="checkbox"/> Taking medication for weight control (ie fen-phen) | <input type="checkbox"/> Taking dietary supplements |
| <input type="checkbox"/> Subject to frequent headaches | <input type="checkbox"/> A smoker or smoked previously |
| <input type="checkbox"/> FEMALE: Taking birth control pills | <input type="checkbox"/> FEMALE: Pregnant |

If any condition or alerts selected above needs further clarification, please explain below:

Do you take antibiotic premedication for your dental visits? If yes, please explain.

Name of physician and their specialty:

Most recent physical exam and purpose:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

Response Date: _____