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

Name			Soc. Sec. #	
Last Name	First Name	Initial		
Address				
City		Zip	Home Phone	
Cell Phone	Email			
Sex D M D F Age Bird	hdate	□ Single □ Ma	arried 🗆 Widowed 🗅 Separated 🗅 Div	orced
Patient Employed by			Occupation	
Business Address			Business Phone	
Business Email				
Whom may we thank for referring you?				
Notify in case of emergency		Home Phone _		
Cell Phone		Business Phone		
Email				
		Primary Insura	nce	
Person Responsible for Account				
	Last Name		First Name	Initial
Relation to Patient	Birthdate		Soc. Sec. #	
Address (if different from patient)				
City				
0. II pl			n d	
Person Responsible Employed by			Occupation	
Business Address			Business Phone	
Business Email				
Insurance Company			Phone	
Insurance Email				
Contract #	Group #_		Subscriber #	
Name of other dependents under this plan				
	A	dditional Insur	ance	
Is patient covered by additional insurance?	Yes □ No			
Subscriber Name		ent	Birthdate	
Address (if different from patient)			oc. Sec. #	
City	State	Zip	Home Phone	
Cell Phone		****	Email	
Subscriber Employed by			Business Phone	
Business Email				
Insurance Company			Phone	
Insurance Email				
Contract #	Group #_		Subscriber #	
Name of other dependents under this plan	TH			

Dental History

What would you like us to do today?		Are you in dental discomfort to do			
			_ Are you in dental discomfort today?		
Date of last dental care	Date	of last x-rays			
Check (✓) yes or no if you have ha	ad problems with any of the following:				
☐ Y ☐ N Bad breath	☐ Y ☐ N Food collection between teeth	☐ Y ☐ N Periodontal treatment	\square Y \square N Periodontal treatment \square Y \square N Sensitivity to sweets		
☐ Y ☐ N Bleeding gums	☐ Y ☐ N Grinding or clenching teeth	☐ Y ☐ N Sensitivity to cold	☐ Y ☐ N Sensitivity when biting		
\square Y \square N Clicking or popping jaw	\square Y \square N Loose teeth or broken fillings	☐ Y ☐ N Sensitivity to hot	☐ Y ☐ N Sores or growths in mouth		
How often do you brush?		Floss?			
	·	with a medical or dental procedure?			
	health or previous treatment	•			
outer mormation about your demai	neath of previous treatment				
	Me	edical History			
Dharisian), many		•			
		Phone			
	Have you had any serious	illnesses or operations? UY UN			
If yes, describe					
Have you ever had a blood transfusion		ate dates			
Have you ever taken Fen-Phen/Redux					
		max, Actonel, Atelvia, Didronel and Boniv	7a. □ Y □ N		
	IN Nursing? IY IN Taking b	irth control pills? Y N			
Check (\checkmark) yes or no whether you l	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 Skin rash		
☐ Y ☐ N Arthritis, Rheumatism	☐ Y ☐ N Epilepsy	☐ Y ☐ N Liver disease	☐ Y ☐ N Spina Bifida		
☐ Y ☐ N Artificial heart valves	☐ Y ☐ N Fainting	☐ Y ☐ N Material allergies (latex, wool, metal,	□ Y □ N Stroke		
☐ Y ☐ N Artificial joints ☐ Y ☐ N Asthma	☐ Y ☐ N Food allergies ☐ Y ☐ N Glaucoma	chemicals)	□ Y □ N Surgical implant		
☐ Y ☐ N Atopic (allergy prone)	Y N Gaucoma	☐ Y ☐ N Mitral valve prolapse	☐ Y ☐ N Swelling of feet or ankles		
☐ Y ☐ N Back problems	☐ Y ☐ N Heart murmur	☐ Y ☐ N Nervous problems	☐ Y ☐ N Thyroid disease or		
☐ Y ☐ N Blood disease	☐ Y ☐ N Heart problems	☐ Y ☐ N Pacemaker/ Heart surgery	malfunction		
☐ Y ☐ N Cancer	Describe	— □ Y □ N Psychiatric care	☐ Y ☐ N Tobacco habit		
☐ Y ☐ N Chemical dependency	☐ Y ☐ N Hemophilia/	☐ Y ☐ N Rapid weight gain or loss	☐ Y ☐ N Tonsillitis		
☐ Y ☐ N Chemotherapy	Abnormal bleeding	☐ Y ☐ N Radiation treatment	☐ Y ☐ N Tuberculosis		
☐ Y ☐ N Circulatory problems	☐ Y ☐ N Herpes	☐ Y ☐ N Respiratory disease	□ Y □ N Ulcer/Colitis		
☐ Y ☐ N Cortisone treatments	☐ Y ☐ N Hepatitis ☐ Y ☐ N High blood pressure	☐ Y ☐ N Rheumatic/Scarlet fever	☐ Y ☐ N Venereal disease		
Is patient currently taking any medica		Does patient have drug allergies? If y	ac list all-		
to patient currently taking any medica	dons. If yes, fist all.	boes patient have drug altergres: if y	cs, list all.		
		_			
	Aı	ıthorization			
I have reviewed the information on the	ais questionnaire, and it is accurate to the	e best of my knowledge. I understand that	this information will be used by the denti-		
		change in my medical status, I will inform			
I authorize the insurance company authorize the use of this signature of		e dentist all insurance benefits otherwi	ise payable to me for services rendered		
		payment of benefits. Lunderstand that I	am financially responsible for all charge		
whether or not paid by insurance.	in secure the p		an anancian, responsible for an effat ge		
Signature		Date			
	gyment is due in full at time of treatment	, unless prior arrangements have been ap			
P	ayment is due in full at time of treatment.	, umess prior arrangements have been ap	proved.		

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