

PATIENT INFORMATION

Full Name _____ Date of Birth _____ Marital Status _____

Home Address _____ City _____

State _____ Zip _____ Social Security # _____

Home Phone _____ Cell Phone _____

Work Phone _____ E-mail Address _____

Employer & Address _____

Dental Insurance Company's Name _____

Address _____

Group # _____ Phone _____

Medical Insurance Company's Name _____ * Please present insurance card for photocopy

How did you choose this office: () Personal referral by _____

() Yellow Pages () Sign () Advertisement () Website () Other

RESPONSIBLE PARTY INFORMATION

(if different from above information or if co-insurance/secondary insurance)

Full Name _____ Date of Birth _____

Home Address _____ City _____

State _____ Zip _____ Social Security # _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer & Address _____

Insurance Company's Name _____

Address _____

Group # _____ Phone _____

MEDICAL INFORMATION

CIRCLE YOUR RESPONSE

Are you currently under medical care? YES NO

If so, for what? _____

Do you have allergies? YES NO

If so, what are they? _____

Do you take medication? YES NO

If so, what are they? _____

Are you pregnant? YES NO

PLEASE CONTINUE ON NEXT PAGE

- Do you or have you ever had any of the following:
- | | |
|--|--|
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Latex Allergies |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bisphosphonate Use |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart Ailment | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Hepatitis or Jaundice | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Herpes Infection/Cold Sores |
| <input type="checkbox"/> Stomach Disorder | <input type="checkbox"/> A.I.D.S. |
| <input type="checkbox"/> Acid Reflux/GERD | |

Is there any other medical information that we should be aware of? _____

DENTAL INFORMATION

DO YOU: (circle your response)

- | | | | |
|--|----------|--|----------|
| Have pain in your teeth or gums? | YES / NO | Have bleeding gums? | YES / NO |
| Have pain in your joints near your ears? | YES / NO | Have bad breath? | YES / NO |
| Habitually grind or clench your teeth? | YES / NO | Have growths or lesions in your mouth? | YES / NO |

Are you happy with the appearance of your teeth?

YES SOMEWHAT NOT AT ALL Comments: _____

Are you apprehensive about dental treatment?

YES SOMEWHAT NOT AT ALL Comments: _____

Please make any additional comments that may be a concern to you: _____

In case of an emergency, notify _____ Phone _____

I understand and agree that payment is required regardless of my insurance status. If one's insurance has not been paid within 60 days, I am ultimately responsible for the balance on my account for any professional services rendered. Balances over 30 days from date of service will be subject to a monthly service fee. In the event of collection procedures the patient (or responsible party) will be liable for any associated fees such as attorney fees, court cost, etc. I have read all the information on this questionnaire and completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

 Signature (parent if patient is a minor)

 Date