Patient Information

Date: (mm/dd/yyyy) _____ Email Address: _____

Patient's Name: _____ _____ _____
Last First Middle

Address: _____ _____ _____ _____
Street City State Zip

Home Phone _____ Birth Date _____ Age _____ SS# _____
(xxx) xxx-xxxx (mm/dd/yyyy) (xxx-xx-xxxx)

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Name: _____ _____ _____ _____
Last First Middle Marital Status

Residence: _____ _____ _____ _____
Street City State Zip

Mailing Address: _____ _____ _____ _____
Street City State Zip

How long at this address: _____ Home Phone: _____ Work Phone: _____
(xxx) xxx-xxxx (xxx) xxx-xxxx

Previous Address (If less than 3 years) _____ _____ _____ _____
Street City State Zip

Social Security Number _____ Birth date _____ Relationship to Patient _____
(xxx-xx-xxxx) (mm/dd/yyyy)

Employer _____ Occupation _____ # of Years Employed _____

Dental Insurance Information

Insured's Name _____ Social Security Number _____
(xxx-xx-xxxx)

Insurance Company _____ Group Number _____ Local Number _____

Insured's Employer _____ Do you have dual coverage?: ◯Yes ◯No

If Yes: Insured's Name _____ Social Security Number _____
(xxx-xx-xxxx)

Insurance Company _____ Group Number _____ Local Number _____

Insured's Employer _____

Emergency Information

Name of nearest relative not living with you:

Complete Address:

Phone Number: (xxx-xxx-xxxx)

Additional Information

Name of Family Members in Treatment:

Patient's Physician Patient's Dentist

Are you taking any medications?: ◯Yes ◯No

If Yes, please list them:

Have you ever had any of the following diseases or medical problems?

Heart Attack / Stroke	◯Yes	◯No	Psychiatric / Learning Problems	◯Yes	◯No
High / Low Blood Pressure	◯Yes	◯No	Epilepsy / Seizures / Fainting Spells	◯Yes	◯No
Diabetes / Tuberculosis (TB)	◯Yes	◯No	Heart Murmur	◯Yes	◯No
Rheumatic Fever	◯Yes	◯No	HIV+ / Aids	◯Yes	◯No
Hemophilia / Abnormal Bleeding	◯Yes	◯No	Heart Surgery / Pacemaker	◯Yes	◯No
Cancer / Chemotherapy / Radiation	◯Yes	◯No	Mitral Valve Prolapse	◯Yes	◯No
Kidney Problems	◯Yes	◯No	Artificial Bones / Joints	◯Yes	◯No
Asthma / Arthritis	◯Yes	◯No	Sinus / Breathing Problems	◯Yes	◯No
Adenoids / Tonsils Removed	◯Yes	◯No	Hepatitis	◯Yes	◯No

List any other medical condition:

Are you aware of any allergies?

Aspirin / Codeine	◯Yes	◯No	Penicillin / Tetracycline / Erythromycin / Sulfa	◯Yes	◯No
Dental Anesthetics	◯Yes	◯No	Latex / Rubber Gloves	◯Yes	◯No
Any Metals / Plastics	◯Yes	◯No	Other	◯Yes	◯No

If "yes" to "Other", please list other allergies

Have you ever had or been evaluated for Orthodontic treatment?	◯Yes	◯No
Have you ever had problems associated with any previous dental work?	◯Yes	◯No
Do you now or have you ever experienced pain / clicking / popping noises in your jaw joint?	◯Yes	◯No
Has your jaw joint ever locked or felt like it was sticking?	◯Yes	◯No
Have you ever had an injury to your mouth / teeth / chin?	◯Yes	◯No

Would you say your over dental health is: ◯ Good ◯ Fair ◯ Poor

Authorizations

I authorize this office to affix my name to any and all claims or documents related to any and all dental benefits due me and my dependents through my employment. I authorize payment of dental benefits otherwise payable to me, directly to this office.

I understand that where appropriate, credit bureau reports may be obtained.

I certify that I have read and understand the foregoing questions. To the best of my knowledge, the foregoing questions have been completely and accurately answered. In addition, I will notify the doctor of any change in my health history.

Patient Signature:_____

Parent or Legal Guardian Signature: _____