*Welcome! We are glad you are here!*

Patient Full Name: (Male/Female)

I prefer to be called: Date Today:

Address: City, Zip:

Date of Birth: Social Security #

Your Phone: Email:

Emergency Contact: Emergency Phone:

**Insurance:**

Employer: Group # (Plan or Policy #):

Dental Insurance Company: (provide card for copy)

Person responsible for the account if other than patient:

Billing Address (if different):

Insured’s Name (if other than patient):

Insured’s Social Security # Insured’s Date of Birth:

**Dental & Medical History:**

Are you allergic to any medications? Which ones:

Are you being treated for any medical condition? If yes, please explain:

List any medications you are currently taking:

WOMEN: Are you pregnant or nursing? YES NO

|  |  |  |
| --- | --- | --- |
| Do you clench or grind your teeth at night or during the day? | Y | N |
| Have you experienced any growth or sore spots in your mouth? | Y | N |
| Do your gums bleed? | Y | N |
| Do you frequently get blisters on your lips or in your mouth? | Y | N |
| Do you have any trouble keeping your mouth open? | Y | N |
| Are your teeth sensitive to hot or cold? | Y | N |

Have you had any of the following:

|  |  |  |
| --- | --- | --- |
| Heart attack or bypass | YES | NO |
| Heart valve disease | Y | N |
| Mitral Valve Prolapse | Y | N |
| Rheumatic fever | Y | N |
| High or low blood pressure | Y | N |
| Blood Disease | Y | N |
| Bleeding Problems (Hemophilia) | Y | N |
| Diabetes | Y | N |
| Respiratory (Asthma, Emphysema, TB) | Y | N |
| Hepatitis | Y | N |
| Kidney Disease | Y | N |
| Stomach or intestinal problems (ulcers) | Y | N |
| Epilepsy | Y | N |
| Hip or joint replacement | Y | N |
| Exposure to AIDS virus | Y | N |
| Substance abuse | Y | N |
| Venereal Disease | Y | N |
| Cancer or cancer treatment | Y | N |

**Financial Agreement and Treatment Consent:**

* I understand that I am responsible for the balance on my account regardless of my insurance status, and that payment is due at the time of service.
* I authorize release of any information necessary to effectively process my claim with my insurance carrier.
* I authorize payment directly to my attending dentist of the group insurance benefits otherwise payable to me.
* I affirm that the information I have provided is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.
* I consent to the use of photographs of my teeth/mouth for educational or marketing purposes.
* I authorize the dental staff to perform the necessary dental services I may need.

**Signature Date:**

If you are filling this form for someone other than yourself, please indicate your relationship to the patient: