

Patient Information

Name _____ Name you go by _____ Social Security # _____
Address _____ City _____ State _____ Zip Code _____
Home Phone _____ Cell Phone _____ E-Mail _____
Birthdate _____ Sex ____ F ____ M
Patient Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Whom may we thank for referring you? _____

Dental History

How can we help you? _____
Last Dental Visit _____ Reason for last visit _____
What things have you liked or not liked at other doctor offices _____
List any past procedures (i.e. whitening, crowns, filling, etc.) _____
Please tell us about any negative experiences or complications you have had in the past _____
Do you experience or would you like to discuss any of the following items? please check

<input type="checkbox"/> missing teeth	<input type="checkbox"/> difficulty with chewing	<input type="checkbox"/> headaches	<input type="checkbox"/> color of teeth
<input type="checkbox"/> bleeding gums	<input type="checkbox"/> sensitivities(even small ones)	<input type="checkbox"/> bad breath	<input type="checkbox"/> appearance of your teeth or smile
<input type="checkbox"/> crooked teeth	<input type="checkbox"/> areas where food gets caught	<input type="checkbox"/> old fillings	<input type="checkbox"/> keeping your teeth
<input type="checkbox"/> veneers	<input type="checkbox"/> drill-less dentistry	<input type="checkbox"/> bridges	<input type="checkbox"/> tooth colored fillings
<input type="checkbox"/> implants	<input type="checkbox"/> air abrasion (decay removal)	<input type="checkbox"/> porcelain crowns	<input type="checkbox"/> whitening your teeth
<input type="checkbox"/> bonding	<input type="checkbox"/> sealants	<input type="checkbox"/> inlays/onlays	<input type="checkbox"/> straightening teeth without braces

Health History

Current medication _____ Reason for medication _____
Current medication _____ Reason for medication _____
Current medication _____ Reason for medication _____
Allergies _____
Past/Present Health Conditions (i.e. Heart, Diabetes, TB, High Blood Pressure, Surgeries, Etc) _____
Person to contact in case of an emergency _____ Phone _____

Authorization

I acknowledge notification and receipt of the Notice of Privacy Practice.

I give consent to use or disclose protected health information to another family member in order to carry out treatment, payment, and healthcare operations. (please list name(s))

Name	Relationship
_____	_____

I authorize use of my name to be printed in the newsletter either as "being welcomed as a new patient or being thanked for referring a patient".

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered.

I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature (Parent or Guardian if under 18 years of age) _____ Date _____