Welcome Form

Patient # _____

SS#/SIN _____

Patient Information (CONFIDENTIAL)

Date _____

Name _____ Birth Date _____ Home Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C._____

Email _____ Cell Phone _____

Check Appropriate Box: □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated

If Student, Name of School/College _____City _____

State/Prov. _____ Zip/P.C. _____ □ Full Time □ Part Time

Patient or Parent/Guardian Employer _____ Work Phone _____

Business Address _____ City _____ State/Prov. _____ Zip/P.C._____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency? _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient_____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birth date _____ Financial Institution _____

Employer _____ Work Phone _____ SS#/SIN _____

Is the person currently a patient in our office? □ Yes □ No

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment. □ Cash □ Personal Check Credit Card □Visa □MC □Discover □AMEX

□ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C._____

Insurance Company _____ Group# _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C._____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? □Yes □No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C._____

Insurance Company _____ Group# _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C._____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

1. Are you under medical treatment now? . . . . □ Yes □ No
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? □Yes □ No If yes, please explain _____ _____
3. Are you taking any medication(s) including non-prescription medicine? □ Yes □ No If yes, please explain _____
4. Have you ever taken Fen-Phen/Redux? . . . . □ Yes □ No
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? . . . . . □ Yes □ No
6. Have you taken Viagra, Revati, Cialis, or Levitra in the last 24 hours? . . . . . □ Yes □ No
7. Do you use tobacco? . . . . . □ Yes □ No
8. Do you use controlled substances? . . . . . □ Yes □ No
9. Do you have or have you had any of the following?
10. Are you wearing contact lenses? . . . . . □ Yes □ No
11. Are you allergic to or have you had any reaction to the following?
    - Local Anesthetics (e.g. Novocain) . . . □ Yes □ No
    - Penicillin or any other Antibiotics? . . □ Yes □ No
    - Sulfa Drugs . . . . . □ Yes □ No
    - Barbiturates . . . . . □ Yes □ No
    - Sedatives . . . . . □ Yes □ No
    - Iodine . . . . . □ Yes □ No
    - Aspirin . . . . . □ Yes □ No
    - Any Metals (e.g. nickel, mercury, etc.) □ Yes □ No
    - Latex Rubber . . . . . □ Yes □ No
    - Other (please list) _____
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks?) . . . . . □ Yes □ No
13. Women Only:
    a) Are you pregnant or think you may be pregnant? . . . . . □ Yes □ No
    b) Are you nursing? . . . . . □ Yes □ No
    c) Are you taking oral contraceptives? . . . . . □ Yes □ No

High Blood Pressure □ Yes □ No	Heart Disease . . . . . □ Yes □ No	Chest Pains . . . . . □ Yes □ No
Heart Attack . . . . . □ Yes □ No	Cardiac Pacemaker . . . □ Yes □ No	Easily Winded . . . . . □ Yes □ No
Rheumatic Fever . . . . □ Yes □ No	Heart Murmur . . . . . □ Yes □ No	Stroke . . . . . □ Yes □ No
Swollen Ankles . . . . . □ Yes □ No	Angina . . . . . □ Yes □ No	Hay Fever/Allergies . . □ Yes □ No
Fainting/Seizures . . . □ Yes □ No	Frequently Tired . . . . . □ Yes □ No	Tuberculosis . . . . . □ Yes □ No
Asthma . . . . . □ Yes □ No	Anemia . . . . . □ Yes □ No	Radiation Therapy . . . □ Yes □ No
Low Blood Pressure □ Yes □ No	Emphysema . . . . . □ Yes □ No	Glaucoma . . . . . □ Yes □ No
Epilepsy/Convulsions □ Yes □ No	Cancer . . . . . □ Yes □ No	Recent Weight Loss . . □ Yes □ No
Leukemia . . . . . □ Yes □ No	Arthritis . . . . . □ Yes □ No	Liver Disease . . . . . □ Yes □ No
Diabetes . . . . . □ Yes □ No	Joint Replacement . . . . □ Yes □ No	Heart Trouble . . . . . □ Yes □ No
Kidney Diseases . . . . □ Yes □ No	Hepatitis/Jaundice . . . . □ Yes □ No	Respiratory Problems . □ Yes □ No
AIDS/HIV Infection □ Yes □ No	Sexually Trns. Disease . □ Yes □ No	Mitral Valve Prolapse . □ Yes □ No
Thyroid Problem . . . . □ Yes □ No	Stomach Issues/Ulcers . □ Yes □ No	Other _____

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

Gums bleed while brushing/flossing? . . . . . □ Yes □ No
Teeth sensitive to hot/cold liquids/foods? . . . □ Yes □ No
Teeth sensitive to sweet/sour liquids/foods? . □ Yes □ No
Do you feel pain in any of your teeth? . . . . . □ Yes □ No
Any sores or lumps in/near your mouth? . □ Yes □ No
Have you had head, neck, or jaw injuries? □ Yes □ No
Experienced any of the following jaw problems?
- Clicking . . . . . □ Yes □ No
- Pain (joint, ear, side of face) . . . . . □ Yes □ No
- Difficulty opening or closing . . . . . □ Yes □ No
- Difficulty chewing . . . . . □ Yes □ No

Do you have any frequent headaches? . . . . □ Yes □ No
Do you clench or grind your teeth? . . . . . □ Yes □ No
Do you bite your lips or cheeks frequently? . □ Yes □ No
Had any difficult extractions in the past? . . . □ Yes □ No
Prolonged bleeding following extraction? . . □ Yes □ No
Have you had any orthodontic treatment? . . . □ Yes □ No
Do you wear dentures or partials? . . . . . □ Yes □ No
If yes, date of placement _____
Have you ever received oral hygiene instructions regarding the care of your teeth and gums? . □ Yes □ No
Do you like your smile? . . . . . □ Yes □ No

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or dependant.

X_____

Signature of patient (or parent/guardian if minor) Date