

# WELCOME

*We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.*

## Patient Information

Name \_\_\_\_\_  
Last First Middle Sex Marital Status

Address \_\_\_\_\_  
Street City State Zip

Birthdate \_\_\_\_\_ E-mail \_\_\_\_\_ Social Security# \_\_\_\_\_  
MM-DD-YYYY 999-99-9999

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ ext. \_\_\_\_\_  
999-999-9999 999-999-9999 999-999-9999

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

General Dentist \_\_\_\_\_ Last Visited \_\_\_\_\_

Whom may we thank for referring you to our office \_\_\_\_\_

## Spouse / Additional Contact Information

Name \_\_\_\_\_  
Last First Middle Marital Status

Address \_\_\_\_\_  
Street City State Zip

Birthdate \_\_\_\_\_ E-mail \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
MM-DD-YYYY

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ ext. \_\_\_\_\_  
999-999-9999 999-999-9999 999-999-9999

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

## Insurance Information

Policy Owner's Name \_\_\_\_\_ Policy Owner's Social Security # \_\_\_\_\_  
999-99-9999

Policy Owner's Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
MM-DD-YYYY

Policy Owner's Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. (plan, local, or policy) \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Insurance Phone No. \_\_\_\_\_

## Secondary Insurance

Policy Owner's Name \_\_\_\_\_ Policy Owner's Social Security # \_\_\_\_\_  
999-99-9999

Policy Owner's Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
MM-DD-YYYY

Policy Owner's Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. (plan, local, or policy) \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Insurance Phone No. \_\_\_\_\_

# Medical History

Are you under the care of a physician? Yes No If Yes, explain \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_ Last Visit \_\_\_\_\_

Address \_\_\_\_\_

Are you pregnant Yes No If so how many weeks \_\_\_\_\_

Have your tonsils or adenoids been removed? Yes No

Have you ever experienced jaw joint pain/ discomfort (TMJ/TMD)? Yes No

Do you have any missing or extra permanent teeth? Yes No

Have you ever had an injury to : (select all that apply) Teeth Mouth Chin

Do you have speech problems? Yes No if Yes, explain \_\_\_\_\_

Do your gums bleed? Yes No Do you smoke? Yes No Do you like your smile? Yes No

Do/Have you have/had any of the following habits?

Lip Sucking/Biting

Nail biting

Prolonged Bottle/Pacifier

Clenching/Grinding Teeth

Mouth Breather

Tongue Thrusting

Thumb/ Finger Sucking

Are you allergic to any of the following?

Aspirin Erythromycin

Codeine Penicillin

Tetracycline Latex

Any Metals/Plastics

Other Allergies/Sensitivities:  
\_\_\_\_\_

List all drugs you are currently taking

List any serious medical condition(s) treated

## Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidences and it is my responsibility to inform this office of any changes in my medical status.

I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.

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

Name of person filling out this form \_\_\_\_\_ Date \_\_\_\_\_