Welcome!

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

Date Soc. Sec. # Birthdate Name Home Phone Address City State Zip E-mail Sex: M F Minor Single Married Long Term Partner Divorced Widowed Separated Employer Business Phone Business Phone Business Address Occupation Who should we thank for referring you? In case of emergency, who should we contact? Phone Phone Person Responsible for Account Law Newe First Newe Notice Notice Relationship to Patient Birthdate Soc. Sec. # Notice Notice Address Home Phone Zip Responsible Party Employed By Business Phone Business Phone Business Address Occupation Insurance Company Insurance Company Address Soc. Sec. # Address Subscriber I.D. # Birthdate Soc. Sec. # Notice Notice Insured Name Law Newe First Newe Notice Notice Insured Name Law Newe First Newe Notice Notice Insurance Company Address	Patient Inf	ormation
Address Cell Phone City State Zip E-mail Sex: M F Minor Single Married Long Term Partner Divorced Widowed Separated Employer Business Address Occupation Widowed Separated Business Address Occupation Who should we tontact? Phone Phone Prim ary Insurance Phone Prime Married Nation Relationship to Patient Birthdate Soc. Soc. # Address City State Zip Responsible Party Employed By Business Phone Business Address Occupation Insurance Company Address Occupation Insurance Company Address Subscriber I.D. # Ad ditional Insurance Company Address Soc. Soc. # Matie Relationship to Patient Birthdate Soc. Soc. # Matie Address Group # Insurance Company Address Insurance Company Address Insurance Company Address Subscriber I.D. # Birthdate Soc. Soc. # Insure Insure Zip Insure Zip Insurance Company Address Business	Date Soc. Sec. #	Birthdate
Address Cell Phone City State Zip Email Sex: M F Minor Single Married Long Term Partner Divorced Widowed Separated Employer Business Address Occupation Widowed Separated Business Address Occupation Who should we tontact? Phone Phone Person Responsible for Account Law Newe Free Newe Netist Relationship to Patient Birthdate Soc. Sec. # Address City State Zip Responsible Party Employed By Business Phone Business Address Occupation Insurance Company Address Occupation Insurance Company Address Subscriber 1.D. # Ad d i t i o n a l l n s u r a n c e Insure Netist Relationship to Patient Birthdate Soc. Sec. # Address Group #	Name	Home Phone
Sex: M F Minor Single Married Long Term Partner Divorced Widowed Separated Employer Business Phone Business Phone Business Phone Business Phone Business Phone Business Address Occupation Phone Phone Phone In case of emergency, who should we contact? Phone Phone Person Responsible for Account Last Name First Name Initial Relationship to Patient Birthdate Soc. Sec. # Address City State Zip Business Phone Business Address Occupation Insurance Company Insurance Company Address Subscriber I.D. # Last Name First Name Intus Relationship to Patient Birthdate Soc. Sec. # Address Occupation Insurance Company Address Occupation Insurance Company Address Subscriber I.D. # Mome First Name Intus Relationship to Patient Birthdate Soc. Sec. # Address City State Zip Insurance Insured Name Know First Name Intus Relationship to Patient Birthdate Soc. Sec. # Intus Address Birthdate Soc. Sec. # Intus Insured Name Know First Name Intus Insured Name Birthdate Soc. Sec. # Intus Insured Name Group # Intus Intus Insurance Company Add		
Employer Business Phone Business Address Occupation Who should we thank for referring you? In case of emergency, who should we contact? Phone In case of emergency, who should we contact? Phone Phone Person Responsible for Account Initial Initial Relationship to Patient Birthdate Soc. Sec. # Address Home Phone Initial City State Zip Responsible Party Employed By Business Phone Business Phone Business Address Occupation Insurance Company Insurance Company Insurance First Name Insurance Relationship to Patient Birthdate Soc. Sec. # Address Subscriber I.D. # Group # Insurance Insurance Insured Name Insure State Zip Insurance Insured Name Birthdate Soc. Sec. # Address Insurance	City State Zip	E-mail
Business Address Occupation Who should we thank for referring you? Phone In case of emergency, who should we contact? Phone Person Responsible for Account Itat Name Relationship to Patient Birthdate Soc. Sec. # Address Home Phone	Sex: M G F Minor Single Married Long	Term Partner Divorced Widowed Separated
Who should we thank for referring you? Phone In case of emergency, who should we contact? Phone Person Responsible for Account Insurance Company Relationship to Patient Birthdate Soc. Sec. # Address Home Phone City State Zip Responsible Party Employed By Business Phone Business Address Occupation Insurance Company Insurance Company Address Subscriber I.D. # Marke First Name Relationship to Patient Birthdate Soc. Sec. # Address Occupation Insurance Company Address Insured Name First Name Install Relationship to Patient Birthdate Soc. Sec. # Address Home Phone Install Insured Name First Name Install Insured Name Birthdate Soc. Sec. # Install Insured Name Birthdate Soc. Sec. # Install Insured Name Birthdate Soc. Sec. # Install Insurance Company Business Phone Insurance Install	Employer	Business Phone
In case of emergency, who should we contact? Phone Phone Phone Prim ary insurance c Birthdate Soc. Sec. # Address Home Phone Tirk Name Soc. Sec. # Address Business Phone Business Phone Occupation Insurance Company Address Group # Insurance Company Address Group # Insurance Company Address Soc. Sec. # Insta Relationship to Patient Birthdate	Business Address	Occupation
Primary Insurance Person Responsible for Account	Who should we thank for referring you?	
Person Responsible for Account Last Name First Name Initial Relationship to Patient Birthdate Soc. Sec. #	In case of emergency, who should we contact?	Phone
Person Responsible for Account Last Name First Name Initial Relationship to Patient Birthdate Soc. Sec. #	Primary In	SILFANCA
Relationship to Patient Birthdate Soc. Sec. #		
Address Home Phone City State Zip Responsible Party Employed By Business Phone Business Phone Business Address Occupation Insurance Company Insurance Company Address Subscriber I.D. # Group # Insurance Company Address Subscriber I.D. # Group # Insured Name Last Name First Name Insured Name Birthdate Soc. Sec. # Address Home Phone City State Zip Insurance Company Insurance Company Business Phone Insurance Insurance Company Business Phone Insurance Insurance Company Group # State Zip		
City	Relationship to Patient Birthdate	Soc. Sec. #
Responsible Party Employed By Business Phone Business Address Occupation Insurance Company Insurance Company Address Subscriber 1.D. # Group # A d d i t i o n a l i n s u r a n c e Insured Name First Name Last Name First Name Address Home Phone City State Zip Insured Employed By Business Phone Insurance Company Insured Company Group # Instract Address Group Group City State Zip Insurance Company Group # Group #		
Business Address Occupation Insurance Company Insurance Company Address Subscriber I.D. # Group # A d d i t i o n a l i n s u r a n c e Insured Name First Name Last Name First Name Relationship to Patient Birthdate Address Home Phone City State Insured Employed By Business Phone Insurance Company Insurance Company	City	State Zip
Insurance Company Address	Responsible Party Employed By	Business Phone
Insurance Company Address Group # Subscriber I.D. # Group # A d d i t i o n a l insurance company Relationship to Patient Birthdate Soc. Sec. # Address Home Phone City State Zip Insurance Company Insurance Company Address Subscriber I.D. # Group #	Business Address	Occupation
Subscriber I.D. # Group #	Insurance Company	
Additional Insurance Insured Name	Insurance Company Address	
Insured Name Last Name First Name Initial Relationship to Patient Birthdate Soc. Sec. #	Subscriber I.D. #	Group #
Insured Name Last Name First Name Initial Relationship to Patient Birthdate Soc. Sec. #	Additional	nsurance
Relationship to Patient		
Address Home Phone City State Insured Employed By Business Phone Insurance Company Insurance Company Address Subscriber I.D. # Group #		
CityStateZip Insured Employed ByBusiness Phone Insurance Company Insurance Company Address Subscriber I.D. #		
Insured Employed By Business Phone Insurance Company Insurance Company Address Subscriber I.D. # Group #		
Insurance Company Insurance Company Address Group # Group #		
Insurance Company Address Group # Group #		
Subscriber I.D. # Group #		

PLEASE COMPLETE REVERSE SIDE

Dental History

Bleeding Gums Orthodontic Blisters on Lips or Mouth Pain Around Finger Nail Biting Periodontal Grinding Teeth Sensitivity	h or Broken c Freatment d Ear I Treatment to Cold	Date of Last X-Rays How Often Do You Floss? How Often Do You Brush? Fillings Sensitivity to Sweets Sensitivity When Biting Sensitivity When Biting Image: Sensitivity Sensitivity Image: Sensitivity Sensi
Medi	cal	History
Physician's Name	Ne	Date of Last Visit
1. Are you currently under medical treatment?	No	 Have you had any allergic reactions to the following: Yes No
 Have you ever had any serious illnesses or operations? 		Local Anesthetics (eg. novocaine)
3. Are you currently taking any medication?		Sulfa Drugs
Please describe:		Sedatives
		Iodine
4. Do you smoke?		Other
5. Do you use alcohol, cocaine or other drugs?		8. (Women Only) Are You: Pregnant?
6. Do you wear contact lenses?		Nursing?
Please check all that apply:		Taking birth control pills?
	-	

AIDS
Anemia.:
Arthritis, Rheumatism
Artificial Heart Valves
Artificial Joints
Asthma
Back Problems
Bleeding abnormally,
with extractions or surgery
Blood Disease
Cancer
Chemical Dependency
Chemotherapy
Chronic Fatigue Syndrome
Circulatory Problems
Congenital Heart Lesions
Cortisone Treatments
Cough - persistent or bloody
Diabetes

Emphysema	
Epilepsy	
Fainting or Dizziness	
Glaucoma	
Headaches	
Heart Murmur	
Heart Problems	
Hepatitis-Type	
Herpes	
High Blood Pressure	
HIV Positive	
Jaundice	
Jaw Pain	
Kidney Disease	
Latex Sensitivity	
Liver Disease	
Low Blood Pressure	
Mitral Valve Prolapse	
Nervous Problems	

Pacemaker
Psychiatric Care
Radiation Treatment
Respiratory Disease
Rheumatic Fever
Scarlet Fever
Shortness of Breath
Sinus Trouble
Skin Rash
Stroke
Swelling of Feet/Ankles
Swollen Neck Glands
Thyroid Problems
Tonsillitis
Tuberculosis
Tumor or growth on head/neck
Ulcer
Venereal Disease
Osteoporosis medication

Assignment and Release

I hereby authorize payment directly to ________ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.