# ★ WELCOME ★

*We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can.*
*If you have any questions we'll be glad to help you.*
*We look forward to working with you in maintaining your dental health.*

Date _____ Home Phone _____

## Patient Information

Name _____ Soc. Sec. # _____

Address _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age ____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

## Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patients) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

## Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (If different from patients) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

*Please Complete Both Sides →*

## Dental History

Reason for Today's Visit _____

Former Dentist _____

Address _____

Date of last dental care _____ Date of last dental X-rays _____

Check (✓) if you have had problems with any of the following:

| | | |
|---|---|---|
| ☐ Bad breath | ☐ Grinding teeth | ☐ Sensitivity to hot |
| ☐ Bleeding gums | ☐ Loose teeth or broken fillings | ☐ Sensitivity to sweets |
| ☐ Clicking or popping jaw | ☐ Peridontal treatment | ☐ Sensitivity when biting |
| ☐ Food collection between teeth | ☐ Sensitivity to cold | ☐ Sores or growths in your mouth |

How often do you floss?_____ How often do you brush?_____

## Medical History

Physician's Name _____ Date of Last Visit _____

Have you ever had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have had problems with any of the following:

| | | | |
|---|---|---|---|
| ☐ AIDS | ☐ Cortisone Treatments | ☐ Hepatitis | ☐ Rheumatic Fever |
| ☐ Anemia | ☐ Cough, Persistent | ☐ High Blood Pressure | ☐ Scarlet Fever |
| ☐ Arthritis, Rheumatism | ☐ Cough up Blood | ☐ HIV Positive | ☐ Shortness of Breath |
| ☐ Artificial Heart Valves | ☐ Diabetes | ☐ Jaw Pain | ☐ Skin Rash |
| ☐ Artificial Joints | ☐ Epilepsy | ☐ Kidney Disease | ☐ Stroke |
| ☐ Asthma | ☐ Fainting | ☐ Liver Disease | ☐ Swelling of Feet or Ankles |
| ☐ Back Problems | ☐ Glaucoma | ☐ Mitral Valve Prolapse | ☐ Thyroid Problems |
| ☐ Blood Disease | ☐ Headaches | ☐ Nervous Problems | ☐ Tobacco Habit |
| ☐ Cancer | ☐ Heart Murmur | ☐ Pacemaker | ☐ Tonsillitis |
| ☐ Chemical Dependency | ☐ Heart Problems | ☐ Psychiatric Care | ☐ Tuberculosis |
| ☐ Chemotherapy | Describe _____ | ☐ Radiation Treatment | ☐ Ulcer |
| ☐ Circulatory Problems | ☐ Hemophilia | ☐ Respiratory Disease | ☐ Venereal Disease |

MEDICATIONS- List medications you are currently taking:

_____

_____

ALLERGIES-

_____

_____

## Authorization

*I authorize* my insurance company to pay to the dentist or dental group 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 of benefits.

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

Signature_____ Date _____

***Payment is due in full at time of treatment unless prior arrangements have been approved.***

Form by: J. Scialdo, Akron, OH 216-628-0265