WELCOME TO THE FAMILY

Date _____

Patient Name _____ Birthdate _____

Address _____ Cell # _____

City _____ State _____ Zip code _____ Home # _____

Responsible Party _____ Cell # _____

Address _____ Home # _____

Email Address _____

Employed By _____ Work # _____

Whom may we thank for referring you? _____

INSURANCE

Name of Dental Insurance Company _____

Address _____

Subscriber's Name _____ Birthdate _____

Relation to Patient _____

Social Security # _____ Group # _____ Policy # _____

Subscriber's Employer _____

Former Dentist's Name _____ Address _____

Physician's Name _____ Phone # _____

How long since your last thorough dental exam? _____

Are you under a doctor's care? _____ Reason? _____

Are you taking any drugs or medications? _____ Name _____

Do you have any Allergies ? _____ Do you use tobacco products? _____

How do you like your smile? _____

	Yes	No
1. Do you use a controlled substance?	☐	☐
2. Have you been hospitalized for any operation or illness within the last 5 years?	☐	☐
If yes, please explain _____		
3. Have you ever taken Fen-Phen/Redux?	☐	☐
4. Have you ever taken Fosamax, Boniva, Actonel or any cancer medication containing Bisphosphonates?	☐	☐
5. Are you taking blood thinners?	☐	☐
6. Have you ever had any knee, hip, or joint replacements?	☐	☐
7. Are you taking any beta-blockers?	☐	☐

Have you ever had:	Yes	No
Heart Trouble	☐	☐
Heart Attack	☐	☐
Stroke	☐	☐
Rheumatic Fever	☐	☐
Diabetes	☐	☐
Hepatitis	☐	☐
Kidney Disease	☐	☐
Abnormal Bleeding	☐	☐
HIV	☐	☐
Other _____	☐	☐
*** Are you pregnant or nursing?	☐	☐

**All professional services rendered are charged to the patient. Insurance forms will be completed as a courtesy to you. The patient is responsible for all fees regardless of insurance coverage. All charges are due at time services are rendered.

Patient's / Parent's Signature _____ Social Security # _____