

# 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		Yes	No
1. Do you use a controlled substance?	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been hospitalized for any operation or illness within the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain _____			Stroke	<input type="checkbox"/>	<input type="checkbox"/>
			Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever taken Fen-Phen/Redux?	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever taken Fosamax, Boniva, Actonel or any cancer medication containing Bisphosphonates?			Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
			Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you taking blood thinners?	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had any knee, hip, or joint replacements?			HIV	<input type="checkbox"/>	<input type="checkbox"/>
			Other _____	<input type="checkbox"/>	<input type="checkbox"/>
7. Are you taking any beta-blockers?	<input type="checkbox"/>	<input type="checkbox"/>	*** Are you pregnant or nursing?	<input type="checkbox"/>	<input type="checkbox"/>

**\*\*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 # \_\_\_\_\_