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 completely.
Thank you!

Patient Information

Patient Name:_____ □ Male □Female
Date of Birth:_____ Preferred Name:_____
Home Address:_____
City:_____ State:_____ Zip:_____
Primary Phone:_____ □Home □Cell Ok to leave message?_____
Secondary Phone:_____ □Home □Cell Ok to leave message?_____
E-mail Address:_____
Martial Status: □Single □Married □Divorced □Widowed □Significant Other
Spouse/Partner's Name:_____
Person(s) ok to release appointment or medically related information concerning you:
_____ Relation:_____
_____ Relation:_____
Employer's Name:_____ Occupation:_____
Employer's Address_____
Employer's Phone Number:_____

Emergency Contact:

Emergency Contact Name:_____
Phone Number:_____ Relation:_____

Insurance Information

Primary Insurance Company:_____ Phone Number:_____
Subscriber's Name:_____ Date of Birth:_____
Relation:_____ Group Number:_____
Subscriber ID Number/Social Security Number:_____

Secondary Insurance Company:_____ Phone Number:_____
Subscriber's Name:_____ Date of Birth:_____
Relation:_____ Group Number:_____
Subscriber ID Number/Social Security Number:_____

Medical History

Are you currently being treated by a physician? □Yes □No
Reason:_____
Physician Name:_____ Phone Number:_____
Do you have any allergies/sensitivities to medication? □ Yes □ No
If yes, please list:_____
Are you currently taking any prescription or over the counter medications? □ Yes □ No
Please list:_____
_____
_____
Have you had any serious illnesses or operations?_____
Please list:_____
_____
Are you pregnant? □ Yes □ No Nursing? □ Yes □No Taking Birth Control? □Yes □No
Check if you have or have ever had any of the following:

□ Anemia	□ Epilepsy	□ Rheumatic/Scarlet Fever
□ Arthritis/Rheumatism	□ Glaucoma	□ Stoke
□ Artificial Heart Valves	□ Headaches	□ Thyroid Problems
□ Artificial Joints	□ Tuberculosis	□ Pacemaker
□ Asthma	□ Hemophilia	□ Liver Disease
□ Blood Disease/Disorder	□ Hepatitis	□ Diabetes
□ Cancer	□ High Blood Pressure	
□ Chemical Dependency	□ HIV/AIDS	□ Mitral Valve Prolapse
□ Chemotherapy/Radiation Therapy	□ Kidney Disease	□ Heart Murmur/Problems

Do you smoke or use smokeless tobacco? □ Yes □ No
Approx how many/times a day?_____

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

I hereby authorize the release of any information pertaining to my medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance.

_____ _____
Patient Signature Date

Welcome

We would like to welcome you and your child to our office. In an effort to provide the best service possible, we ask you to fill out this form completely.
Thank you!

Patient Information

Patient Name:_____ □ Male □Female
Date of Birth:_____ Preferred Name:_____
Home Address:_____
City:_____ State:_____ Zip:_____
Primary Phone:_____ □Home □Cell Ok to leave message?_____
Parent E-mail Address:_____

Parent/Guardian Information

Parents' Martial Status: □Single □Married □Divorced □Widowed □Significant Other
Mother's Name:_____Date of Birth:_____
Address (if different from child's):_____
City:_____ State:_____ Zip Code:_____
Primary Phone:_____ □Home □Cell Ok to leave message?_____
Secondary Phone:_____ □Home □Cell Ok to leave message?_____
Employer's Name:_____
Occupation:_____

Father's Name:_____Date of Birth:_____
Address (if different from child's):_____
City:_____ State:_____ Zip Code:_____
Primary Phone:_____ □Home □Cell Ok to leave message?_____
Secondary Phone:_____ □Home □Cell Ok to leave message?_____
Employer's Name:_____
Occupation:_____

Emergency Contact Information:

Emergency Contact Name (other than parent):_____
Phone Number:_____Relation:_____

Insurance Information

Primary Insurance Company:_____ Phone Number:_____
Subscriber's Name:_____ Date of Birth:_____
Relation:_____ Group Number:_____
Subscriber ID Number/Social Security Number:_____

Secondary Insurance Company:_____ Phone Number:_____
Subscriber's Name:_____ Date of Birth:_____
Relation:_____ Group Number:_____
Subscriber ID Number/Social Security Number:_____

Child's Dental History

Who can we thank for referring you to our office?:_____
Has your child ever experienced jaw joint pain/discomfort?_____
Does your child have any missing or extra permanent teeth?_____
Has your child ever had an injury to (select all that apply):
□Teeth □Mouth □Chin
Does your child have any speech problems?_____
Does your child currently or has your child ever had any of the following habits (check all that apply):
□ Clenching/Grinding Teeth
□ Lip sucking
□ Mouth Breathing
□ Nail Biting
□ Thumb/Finger Sucking
□ Chewing/Eating Problems

Is there anything about your child's smile that he/she is self concisions about or that they would like to change? _____

Medical History

Is your child currently being treated by a physician? □Yes □No
Reason:_____
Physician Name:_____ Phone Number:_____
Does your child have any allergies/sensitivities to medication? □ Yes □ No
If yes, please list:_____
Is your child currently taking any prescription or over the counter medications?
□ Yes □ No
Please list:_____
_____
_____
Has your child had any serious illnesses or operations?_____
Please list:_____
_____
Are you pregnant? □ Yes □ No Nursing? □ Yes □No Taking Birth Control? □Yes □No
Check if you have or have ever had any of the following:

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□ Arthritis/Rheumatism	□ Glaucoma	□ Stoke
□ Artificial Heart Valves	□ Headaches	□ Thyroid Problems
□ Artificial Joints	□ Tuberculosis	□ Pacemaker
□ Asthma	□ Hemophilia	□ Liver Disease
□ Blood Disease/Disorder	□ Hepatitis	□ Diabetes
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_____ _____
Parent/Guardian Signature Date