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Patient Welcome Form And Health History

About You

Name _____
I preferred to be called _____
Address _____
City _____ State _____ Zip _____
Home Phone Number _____
Pager/Cellular _____
Birthdate _____/_____/_____ Age _____
Male____ Female ____ Married ____ Single ____
Divorced ____ Widowed ____ Separated ____
Social Security # _____
Occupation _____
Employer _____
Bus. Address _____
Bus. Phone # _____ Ext._____
E-mail Address _____
Best time and place to reach you _____
_____
Hobbies or Interests _____

If This Appointment is for Your Child - Fill in this portion

Child's Name _____
Prefers to be called _____
Address (if different) _____
City _____ State _____ Zip _____
Phone # _____
Birthdate _____/_____/_____ Age _____
Male _____ Female _____
School _____ Grade_____
Social Security # _____

Dental Insurance

Primary Carrier

Insurance Company _____
Address _____
Phone # _____
Group # _____
Insured's name _____
Relation to Patient _____
Date of Birth_____Date Employed _____
Union/Local #_____
Employee # _____

Secondary Carrier

Insurance Company _____
Insured's Name _____

Spouse

Name _____
Occupation _____
Employer _____
Bus. Address _____
Bus. Phone # _____ Ext._____
Social security # _____

Account Information

Person financially responsible

Name _____
Relation to Patient _____
Address _____
City _____ State _____ Zip _____
Phone # _____

Getting to Know You

Is another member of your family or relative a patient at our office?

Name _____
Relationship_____
Whom may we thank for this referral?_____
Your Former Address
City _____ State _____ Zip _____

Person to contact in case of emergency

Name _____
Phone # _____
Relationship_____

Consent

The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication or therapy that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are. rendered unless financial arrangements have been made. I further understand that a 1½% finance charge (18% annually) will be added to any balance over 60 days. In the event of default (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.
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 confidence and It is my responsibility to inform this office of any changes in my medical status.

Patient_____Date _____

Witness_____Parent or Responsible Party_____

Relationship to Patient_____

We shall endeavor to make your visits as convenient and pleasant as possible. If at any time, you have any questions regarding your treatment, appointments, or fees, please ask.

Health History

Yes No Have you been a patient in the hospital during the past two years?
Yes No Have you been under the care of a medical doctor during the past two years?
Physician's Name_____Phone Number_____
Address_____
Yes No Have you taken any medication or drugs during the past two years?
Yes No Are you now taking any medication, drugs or pills?
If yes, please list_____
Yes No Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? If yes, please list_____
Yes No Are you aware of being allergic to or have you ever reacted adversely to any metals?
If yes please explain_____

Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure	Yes	No	Artificial Joints (Hip, Knee, etc.)	Yes	No	Hepatitis B & C (serum)	Yes	No
Heart Disease or Attack	Yes	No	Kidney Trouble	Yes	No	Venereal Disease	Yes	No
Angina Pectoris	Yes	No	Ulcers	Yes	No	A.I.D.S.	Yes	No
Congenital Heart Disease	Yes	No	Diabetes	Yes	No	H.I.V. Positive	Yes	No
Heart Murmur	Yes	No	Thyroid Problems	Yes	No	Cold Sores/Fever Blisters	Yes	No
High Blood Pressure	Yes	No	Glaucoma	Yes	No	Blood Transfusion	Yes	No
Arteriosclerosis	Yes	No	Cosmetic Surgery	Yes	No	Hemophilia	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Anemia	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Sickle Cell Disease	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Bruise Easily	Yes	No
Heart Surgery	Yes	No	Asthma	Yes	No	Liver Disease	Yes	No
Rheumatic Fever	Yes	No	Hay Fever	Yes	No	Yellow Jaundice	Yes	No
Arthritis	Yes	No	Allergies or Hives	Yes	No	Epilepsy or Seizures	Yes	No
Rheumatism	Yes	No	Sinus Trouble	Yes	No	Fainting or Dizzy Spells	Yes	No
Cortisone Medication	Yes	No	Radiation Therapy	Yes	No	Nervousness	Yes	No
Drug Addiction	Yes	No	Chemotherapy	Yes	No	Psychiatric Treatment	Yes	No
Stroke	Yes	No	Hepatitis A (infectious)	Yes	No	Developmentally Disabled	Yes	No

For Women Only:

Yes No Are you pregnant? If Yes, what month?
Yes No Are You Nursing?
Yes No Are you taking birth control pills?

Dental Health History

Yes No Do you expect to keep your teeth a lifetime?
If you could change one thing about your smile what would it be?_____
Yes No If we could offer you a simple, inexpensive way to whiten your teeth, would you?
Yes No Are you experiencing any sensitivity with your teeth, jaws or face at this time?
Yes No Are any of your teeth sensitive to hot or cold, sweet, or chewing?
Yes No Do you chew on both sides of your mouth? If not, why? _____
Yes No Do you floss?
How frequently do you brush your teeth?_____
Yes No Have you received any professional instruction on brushing and flossing?
Yes No Do your gums ever feel swollen?
Yes No Does food pack between your teeth? Where?_____
Yes No Have you had local anesthetic for dental treatment?
Yes No Any reaction to this anesthetic?
Yes No Do you prefer local anesthetic for dental treatment?
Yes No Have you been advised to take antibiotic prior to dental treatment?
Yes No Have dental treatments ever been suggested to you that weren't performed?
If so what was proposed?_____
Why did you decline those proposals?_____
Yes No Have you ever had: Orthodontics - Oral Surgery - Periodontics - Bite Adjustment
Yes No Have you experienced any of the following problems with the Jaw? Clicking–Pain–Difficulty in opening–Clenching