

PATIENT INFORMATION

We are pleased to welcome you to our office. 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.

PERSONAL

Name: _____
Last First MI (Preferred)

Birthdate: _____ SS #: _____ Gender: ☐ M ☐ F Married: ☐ Y ☒ N

Work Phone: _____ Wireless Phone: _____

Email: _____

Preferred Contact Method: ☐ Home Phone ☐ Work Phone ☐ Wireless Phone ☐ Email ☐ Text

Preferred Contact Method for Confirmations ☐ Home Phone ☐ Work Phone ☐ Wireless Phone ☐ Email ☐ Text

Preferred Contact Method for Recall: ☐ Home Phone ☐ Work Phone ☐ Wireless Phone ☐ Email ☐ Text

Student status if dependent over 19 (for ins) ☐ Non Student ☐ Full Time ☐ Part Time

How did you hear about us?

(If someone referred you here, please enter their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family: ☐

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

INSURANCE POLICY 1

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Subscriber ID #: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Subscriber ID #: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

MEDICAL HISTORY

Last Name: _____ First Name: _____ Birthdate: _____

Name of Medical Doctor: _____ City/State: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

List all medications that you are now taking:

****EXISTING PATIENTS**** Check the box next to any medication no longer being taken.

- | | |
|-----------------------------------|------------------------------------|
| 1. ☐ _____ | 6. ☐ _____ |
| 2. ☐ _____ | 7. ☐ _____ |
| 3. ☐ _____ | 8. ☐ _____ |
| 4. ☐ _____ | 9. ☐ _____ |
| 5. ☐ _____ | 10. ☐ _____ |

Are you allergic to any of the following?

Y N

- | | | |
|--------------------------|--------------------------|------------|
| ☐ | ☐ | Anesthetic |
| ☐ | ☐ | Aspirin |
| ☐ | ☐ | Codeine |
| ☐ | ☐ | Ibuprofen |

Other allergies not listed above: _____

Y N

- | | | |
|--------------------------|--------------------------|------------|
| ☐ | ☐ | Iodine |
| ☐ | ☐ | Latex |
| ☐ | ☐ | Penicillin |
| ☐ | ☐ | Sulfa |

Do you have any of the following medical conditions?

Y N

- | | | |
|--------------------------|--------------------------|---------------------|
| ☐ | ☐ | Asthma |
| ☐ | ☐ | Bleeding Problems |
| ☐ | ☐ | Cancer |
| ☐ | ☐ | Diabetes |
| ☐ | ☐ | Heart Murmur |
| ☐ | ☐ | Heart Trouble |
| ☐ | ☐ | High Blood Pressure |
| ☐ | ☐ | Joint Replacement |

Other conditions not listed above: _____

Y N

- | | | |
|--------------------------|--------------------------|-----------------------|
| ☐ | ☐ | Kidney Disease |
| ☐ | ☐ | Liver Disease |
| ☐ | ☐ | Pregnancy |
| ☐ | ☐ | Psychiatric Treatment |
| ☐ | ☐ | Rheumatic Fever |
| ☐ | ☐ | Sinus Trouble |
| ☐ | ☐ | Stroke |
| ☐ | ☐ | Ulcers |

Tobacco use? If so, what kind and how much? _____

Unusual reaction to dental injections? _____

Reason for today's visit _____

Are you in pain? _____

New Patients:

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? _____

Do you have BiteWing x-rays that are less than 1 year old? _____

Name of former Dentist: _____ City/State: _____

Date of last cleaning and exam: _____

Patient/Guardian Signature _____

Date: _____

Notice of Privacy Policies

Last Name: _____ First Name: _____ Birthdate: _____

Date: 09/10/2025

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

Signature