Welcome Form

Patient Information:

Name _____Birth date _____ Phone _____
Address_____Apt#_____
City_____ State_____ Zip Code_____ SSN_____-_____-_____
E-mail_____+_____
Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Patient's Employer _____Work Phone _____
Business Address _____City _____State _____ Zip _____
Whom may we thank for referring you? _____

Responsible Party: (If someone other than yourself will be paying for your services)

Name: _____Relationship to Patient _____
Billing Address _____City _____State _____Zip_____
Phone _____Work Phone _____Social Security _____-____-_____
Is this person currently a patient in our office? _____

In Event of Emergency:

Whom Should We Contact? _____ Relationship to Patient_____
Home Phone _____Work Phone _____Cell Phone _____

Medical Information:

Who is your Medical Doctor? _____ Phone _____
Pharmacy Information:
Pharmacy _____ Pharmacy's Phone _____
Address_____
City_____ State _____Zip Code_____

Patient Medical History: (Please Circle)

Are you under any medical treatment now?	YES	NO
Have you ever been hospitalized for a surgical operation or serious illness?	YES	NO
Do you use any kind of tobacco?	YES	NO
Do you suffer from addiction to alcohol, cocaine, or other drugs of any kind?	YES	NO
Do you currently take any blood thinners?	YES	NO

Women Only:

Are you pregnant or think you might be?	YES	NO
Are you nursing?	YES	NO
Are you taking birth control?	YES	NO

Are you allergic or have you had a reaction to any of the following?

Local Anesthetics	YES	NO
Aspirin	YES	NO
Codeine	YES	NO
Erythromycin	YES	NO
Latex	YES	NO
Penicillin	YES	NO
Sedatives	YES	NO
Sulfa Drugs	YES	NO
Other (Please specify in the space below):		

Do you have or have you had any of the following?

Anemia	YES	NO
Angina	YES	NO
Arthritis	YES	NO
Asthma	YES	NO
Respiratory Problems	YES	NO
Cancer	YES	NO
Radiation Therapy	YES	NO
Leukemia	YES	NO
Cardiac Pacemaker	YES	NO
Chest Pains	YES	NO
Diabetes	YES	NO
Recent Weight Loss	YES	NO
Emphysema	YES	NO
Epilepsy/Convulsions	YES	NO
Fainting/Seizures	YES	NO
Frequently Tired	YES	NO
Stomach Troubles	YES	NO
Easily Winded	YES	NO

Hay Fever/Allergies	YES	NO
Glaucoma	YES	NO
Rheumatic Fever	YES	NO
Kidney Diseases	YES	NO
Liver Disease	YES	NO
Stroke	YES	NO
Heart Attack	YES	NO
Heart Disease	YES	NO
Heart Murmur	YES	NO
Heart Trouble	YES	NO
Hepatitis/Jaundice	YES	NO
High Blood Pressure	YES	NO
Low Blood Pressure	YES	NO
Joint Replacement	YES	NO
Thyroid Problem	YES	NO
Swollen Ankles	YES	NO
Sexually Trans. Disease	YES	NO
AIDs or HIV Infection	YES	NO

Medications Taken at This Time:

Name of Medication:

_____

_____

_____

_____

_____

_____

_____

_____

Reason for Medication:

_____

_____

_____

_____

_____

_____

_____

_____

Patient Dental History:

Please circle if you have any of the following problems:

Blisters/sores in or around mouth	YES	NO
Broken/chipped teeth	YES	NO
Discomfort, clicking, or popping jaw	YES	NO
Locking jaw	YES	NO
Lost/broken fillings	YES	NO
Red, swollen, or bleeding gums	YES	NO
Ringing in ears	YES	NO
Sensitive tooth, teeth, or gums	YES	NO
Stained teeth	YES	NO
Teeth grinding	YES	NO

Have you ever had any difficult extraction in the past?	YES	NO
Have you had any orthodontic work?	YES	NO
Have you ever had any prolonged bleeding following an extraction?	YES	NO
Have you ever had instruction on the correct method for brushing your teeth?	YES	NO
Have you ever had instruction on correct care of your gums?	YES	NO

Any specific questions or concerns you want us to address:

_____

_____

_____

_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge.
The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care third party and/ or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature_____ Date_____

---------- Do Not Write Below This Line ----------

Doctor's Comments:

Doctor's Signature: _____ Date: _____