WELCOME

PATIENT INFORMATION

Name: _____ SS#: _____ - ____ - _____ Driver License#: _____
Last First Middle

Address: _____
Street Apt City State Zip

Sex: ☐M ☐ F Age: _____ Birth date: ____/____/____ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Occupation: _____ Employer/School: _____

Employer's/School address: _____

Spouse's Name: _____ Birth date: ____/____/____ SS#: _____ - ____ - _____

Spouse's Employer: _____

PHONE NUMBERS

Home: (_____)_____ Cell Phone: (_____)_____ Work: (_____)_____ Ext: _____

Spouse's Work: (_____)_____ Other: (____)_____ E-mail: _____

Best time and place to reach you: _____

IN CASE OF AN EMERGENCY CONTACT: (Someone who does not live in your household)

Name: _____ Relationship: _____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone:: (_____)_____

DENTAL INSURANCE

Name of Person Responsible for this Account: _____ Relationship to Patient: _____

SS#: _____/____/_____ Birth date: ____/____/_____ Driver's License #: _____

Address (if different from above): _____
Street City State Zip

PRIMARY DENTAL INSURANCE

Subscriber's Name: _____ Birth date: ____/____/____ SS#: _____ - ____ - _____

Relationship to patient: _____ Address (If different from above): _____

Employer: _____Employer's Address: _____

Insurance Co: _____Group #: _____ Policy/Id #: _____

SECONDARY DENTAL INSURANCE

Subscriber's Name: _____ Birth date: ____/____/_____ SS#: _____ - ____ - _____

Relationship to patient: _____ Address (If different from above): _____

Employer: _____Employer's Address: _____

Insurance Co: _____Group #: _____ Policy/Id #: _____

ASSIGNMENT AND RELEASE:

I hereby authorize this Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.
I understand that I'm responsible for payment of services rendered whether or not paid by the insurance, and also for paying any co-payments and deductibles. I hereby authorize All Dent Dental Center to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submission.

_____
Responsible Party Signature Relationship Date

HEALTH HISTORY

Patient's Name: _____

1. Your current physical health is: ☐Good ☐Fair ☐Poor

2.Are you currently under the care of a physician? ☐Yes ☐No If Yes, please explain: _____

Doctor's name: _____ Phone Number: _____

3. Have you ever been Hospitalized? ☐Yes ☐No If yes, please explain: _____

4. Have you ever been pre-medicated with antibiotics for your dental treatment? ☐Yes ☐No

5.Do you use any form of Tobacco? ☐Yes ☐No If yes, how much? _____ ☐Cigarettes ☐Cigars ☐Chew

6. Are you using any recreational drugs(marijuana, cocaine,…) or controlled substance? ☐Yes ☐No

7. Do you consume alcoholic beverages? ☐Yes ☐No If yes, how much? _____

8.Have you ever taken "Fen-Phen" or "Redux"? ☐Yes ☐No

9.Do you have or have you had any of the following? (*Please check Yes or No*)

AIDS/HIV	☐Yes ☐No	Drug / alcohol Abuse	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No
Anemia	☐Yes ☐No	Emphysema	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No
Arthritis, Rheumatism	☐Yes ☐No	Epilepsy/Seizures	☐Yes ☐No	Nervous disorder	☐Yes ☐No
Artificial Heart Valves	☐Yes ☐No	Fainting or dizziness	☐Yes ☐No	Psychiatric Care	☐Yes ☐No
Artificial Joints	☐Yes ☐No	Glaucoma	☐Yes ☐No	Radiation treatment	☐Yes ☐No
Asthma	☐Yes ☐No	Head Injuries	☐Yes ☐No	Respiratory Disease	☐Yes ☐No
Bleeding Excessively	☐Yes ☐No	Heart Attack	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Blood Disease	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Sickle Cell Disease	☐Yes ☐No
Blood Transfusion	☐Yes ☐No	Heart Pace Maker	☐Yes ☐No	Sinus Trouble	☐Yes ☐No
Bruise Easily	☐Yes ☐No	Hemophilia	☐Yes ☐No	Stomach Ulcer	☐Yes ☐No
Cancer	☐Yes ☐No	Hepatitis, Type___	☐Yes ☐No	Stroke	☐Yes ☐No
Chemotherapy	☐Yes ☐No	Herpes	☐Yes ☐No	TMJ Disorder	☐Yes ☐No
Circulatory Problems	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Tonsillitis	☐Yes ☐No
Cold Sores	☐Yes ☐No	Hives or Rash	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Congenital Heart Lesion	☐Yes ☐No	Kidney Disease	☐Yes ☐No	Tumor or Growths	☐Yes ☐No
Cortisone Treatment	☐Yes ☐No	Liver Disease	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Diabetes	☐Yes ☐No	Other _____		Other _____	

Women:

Are you pregnant? ☐Yes ☐No Due date _____ Are you nursing? ☐Yes ☐No

Taking birth control pills? ☐Yes ☐No

MEDICATIONS

List any medications you are taking and the condition you are taking them for:

_____

_____

_____

ALLERGIES

☐ No Known Allergies
☐ Aspirin
☐ Codeine
☐ Latex
☐ Other _____
☐ Local Anesthetics
☐ Metal/ Jewelry
☐ Penicillin
☐ Sulfa

I certify that the above information is complete and accurate and it is my responsibility to inform this office of any changes.

Signature: _____ **Date:** _____

(If Patient is Minor, include printed name and signature of Parent or Guardian)

Office Use Only

Date: _____ **Signature:** _____ **Comments:** _____