# INTRODUCTORY FORM

**Please print clearly and complete all items** Date:_____

Patient's Name: _____
LAST FIRST INITIAL

Age:_____ Patient's S.S. #_____ Patient's Birthdate:_____

Patient's Address:_____
STREET CITY STATE ZIP

**Patient's Home Phone:**_____ **Patients Business Phone:**_____

Patient's Cell Phone:_____

Patient's Email:_____

**Person responsible for this account:**

Name: Dr. Mrs.
Mr. Ms._____

Address: _____
STREET CITY STATE ZIP

Home Phone:_____ Business Phone:_____

**Dental Insurance Information:**

**Primary Coverage:**

Subscriber Name:_____

Social Security Number:_____ Birthdate:_____

Employer:_____

Insurance Company:_____ Group #:_____

**Person to notify in case of emergency:**

Name:_____

Address: _____

Phone Number(s): _____

Person who referred you:_____

**I accept financial responsibility for payment of this account.**

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

**I HEREBY AUTHORIZE** PAYMENT DIRECTLY TO THE ABOVE NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

_____ _____
SIGNED (INSURED PERSON) DATE

# DENTAL HISTORY

Previous Dentist:

Date of last visit:_____

Have you ever had any problems associated with previous dental treatment:_____

_____

Have you ever had any problems with dental anesthesia:_____

Does dental treatment make you nervous ❑ No ❑ Slightly ❑ Moderately ❑ Extremely

**Do you have the following:**

Previous Periodontal Treatment:..... ❑
Previous Orthodontic Treatment:..... ❑
Sweling, Lumps In Mouth: ..... ❑
Loose Teeth:..... ❑
Missing Teeth: ..... ❑
Bleeding, Sore Gums:..... ❑
Clicking, Popping of Jaw:..... ❑
Clenching, Grinding of Teeth:..... ❑
Sensitive Teeth:..... ❑
Implants, Partials, Dentures:..... ❑

**Medical History**

Has there been any change in your health in the past year:_____

_____

Are you currently under the care of a physician: _____

Physician's Name: _____

Are you allergic to, or have you reacted adversely to:

Penicllin: ❑ Other antibiotics: ❑ Sulfa drugs: ❑ Codeine: ❑

Local anesthetics: ❑ Aspirin: ❑ Iodine: ❑ Other Medications:_____

**Do you have/have had any of the following:**

Eye Diseases/Glaucoma:..... ❑
Convulsions/Epilepsy: ..... ❑
Tuberculosis: ..... ❑
Asthma: ..... ❑
Diabetes:..... ❑
Rheumatic Fever: ..... ❑
High/Low Blood Pressure: ..... ❑
Mitral Valve Prolapse: ..... ❑
Angina: ..... ❑
Stroke: ..... ❑
Sinus Problems:..... ❑
Dizziness/Fainting:..... ❑
Emphysema:..... ❑
Persistent Cough:..... ❑
Hepatitis:..... ❑
Heart Murmur:..... ❑
Heart Surgery:..... ❑
Previous Heart Attack:..... ❑
Abnormal Bleeding:..... ❑
Artificial Joint:..... ❑
Immune System Disorder (Including AIDS, HIV, ARC): ..... ❑
Other Allergies:_____

Please list all current medications (prescription and non-prescription):_____

_____

Is there anything *YOU* think we should know about your general health:_____

_____