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:______________

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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:______________

<u>Do you have/have had any of the following:</u>

- 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):______________

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

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