WELCOME FORM

About You

Today's Date: ____________________

Patient Name: ____________________
Last First MI

What you prefer to be called: ____________________ Male ☐ Female ☐

Birth date: ____________________ Age: __________

SS#: ____________________

Drivers License # ____________________

Street Address: ____________________

City ____________________ State______ Zip __________

Home Phone: ____________________

Work Phone: ____________________

Cell Phone: ____________________

E-mail Address: ____________________

Referred By: ____________________

Employer: ____________________ How long? __________

Employer's Address: ____________________

City ____________________ State______ Zip __________

Occupation: ____________________

Account Information

Person ultimately responsible for this account:

Name: ____________________

Relation: ____________________

Billing Address: ____________________

City ____________________ State______Zip__________

Drivers License # ____________________

Work Phone: ____________________

Emergency Contact

Who should we contact? ____________________

Relation: ____________________

Home Phone: ____________________

Work Phone: ____________________

Who is your medical doctor: ____________________

M.D.'s Phone: ____________________

Dental Information

Please indicate any of the following situations:

☐ Discomfort, clicking or popping jaw ☐ Stained Teeth ☐ Red, swollen or bleeding gums ☐ Teeth Grinding ☐ Locking Jaw

☐ Sensitive tooth, teeth or gums ☐ Bad Breath ☐ Blisters/Sores in or around the mouth ☐ Broken/Chipped Tooth/Fillings ☐ Snoring

☐ Other: ____________________

Do you have trouble getting numb? ☐ Yes ☐ No

Family history of: ☐ gum disease ☐ tooth problems

What would make your dental experience great? ____________________

Previous Dentist Name ____________________ Phone # ____________________

Last Dental Exam: __________ Last Dental X-rays __________

Times of day you brush? __________ Times per week you floss/tpick? __________

What type of toothbrush bristles do you use? ☐ Soft ☐ Medium ☐ Hard ☐ Electric

How would you rate your smile? 1 2 3 4 5 6 7 8 9 10
WORST ← → BEST

(Continued on back)

WELCOME FORM (2)

Medical History

Are you taking any of the following medications? ☐ Nerve Pills ☐ Pain Killers (including aspirin) ☐ Muscle relaxers ☐ Stimulants ☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Other

Do you or have you ever had any of the following diseases or medical conditions? (Circle Yes or No)

Y N Heart Attack/Stroke	**Y N** Kidney Problems	**Y N** Cancer/Tumors	**Y N** Chemotherapy	**Y N** Heart Surg./Pacemaker	**Y N** Liver Problems
Y N Shingles	**Y N** Asthma	**Y N** Heart Murmur	**Y N** Respiratory Problems	**Y N** Hepatitis	**Y N** Difficulty Breathing
Y N Rheumatic Fever	**Y N** Sinus Problems	**Y N** HIV+/AIDS/ARC	**Y N** Diabetes/hypoglycemia	**Y N** Mitral Valve Prolapse	**Y N** StomachProblems/Ulcers
Y N Arthritis/Rheumatism	**Y N** Leukemia	**Y N** Artificial Valves	**Y N** Psychiatric Problems	**Y N** Artificial Bones/Joints	**Y N** Anemia
Y N Heart Disease	**Y N** Emphysema	**Y N** High/Low Blood Pressure	**Y N** Congenital Heart Defect	**Y N** Alcohol/Drug Abuse	**Y N** Fainting/Seizures/Epilepsy
Y N Bleeding Problems	**Y N** Chest Pains	**Y N** Tuberculosis TB	**Y N** Severe/Frequent Headaches	**Y N** Glaucoma	**Y N** Scarlet Fever
Y N Jaw Problems	**Y N** TMJ/TMD	**Y N** Frequent Neck Pain	**Y N** Back Problems	**Y N** Gluten Sensitivity	

Please list any other medical condition(s) you have or ever had: ______________________________

____

Are you allergic to any of the following? ☐ Latex ☐ Penicillin/Amoxicillin ☐ Tetracycline ☐ Aspirin ☐ Dental Anesthetics ☐ Others: ______________

Do you use tobacco? ☐ No ☐ Yes/How used? ______________ How much? ______________ How long? ______________

Please rate your general health from 1-10 _______ Do you wear contact lenses? ☐ Yes ☐ No

For Women: Are you taking birth control pills? ☐ Yes ☐ No ______________

How many children have you had? ______________

Are you pregnant? ☐ Yes ☐ No How long? ______________

Are you nursing? ☐ Yes ☐ No

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at time of visit, unless other arrangements have been made with the Office Manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office the information I have provided.

Signature ______________________________ Date: ______________________________

☐ Adult ☐ Patient ☐ Parent or Guardian ☐ Spouse

UPDATE (OFFICE USE ONLY)

Initials ______________________ Date ______________

Comments ______________________________

Initials ______________________ Date ______________

Comments ______________________________

Initials ______________________ Date ______________

Comments ______________________________

Initials ______________________ Date ______________

Comments ______________________________