

# WELCOME to Dental Innovations

We are please to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

## PATIENT INFORMATION

Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_  
Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Single  Married  Widowed  Separated  Divorced  
Patient Employed by \_\_\_\_\_ Business Phone \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Email \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
Notify in case of emergency \_\_\_\_\_ Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Email \_\_\_\_\_

## PRIMARY INSURANCE

Person Responsible for Account \_\_\_\_\_  
Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_  
Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address (if different from patient) \_\_\_\_\_ Home Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Email \_\_\_\_\_  
Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_  
Business Email \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_  
Insurance Email \_\_\_\_\_  
Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_  
Name of other dependents under this plan \_\_\_\_\_

## ADDITIONAL INSURANCE

Is patient covered by additional insurance?  Yes  No  
Subscriber Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address (if different from patient) \_\_\_\_\_ Social Security # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Email \_\_\_\_\_  
Subscriber Employed by \_\_\_\_\_ Business Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_  
Insurance Email \_\_\_\_\_  
Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_  
Name of other dependents under this plan \_\_\_\_\_

## DENTAL HISTORY

What would you like us to do today? \_\_\_\_\_

Are you in dental discomfort today? \_\_\_\_\_

Former Dentist \_\_\_\_\_ Address \_\_\_\_\_

Dentist's Email \_\_\_\_\_ Phone \_\_\_\_\_

Date of last dental care \_\_\_\_\_ Date of last x-rays \_\_\_\_\_

**Check (✓) yes or no if you have had problems with any of the following:**

<input type="checkbox"/> Y <input type="checkbox"/> N Bad breath	<input type="checkbox"/> Y <input type="checkbox"/> N Food collection between teeth	<input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting
<input type="checkbox"/> Y <input type="checkbox"/> N Periodontal treatment		<input type="checkbox"/> Y <input type="checkbox"/> N Clicking or popping jaw
<input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets		<input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth or broken fillings
<input type="checkbox"/> Y <input type="checkbox"/> N Bleeding gums		<input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to hot
<input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching teeth		<input type="checkbox"/> Y <input type="checkbox"/> N Sores or growths in mouth
<input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to cold		

How often do you brush? \_\_\_\_\_ Floss? \_\_\_\_\_

How do you feel about the appearance of your teeth? \_\_\_\_\_

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?

Y  N If yes, describe \_\_\_\_\_

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Date of last visit \_\_\_\_\_ Have you had an serious illnesses or operations?  Y  N

If yes, describe \_\_\_\_\_

Are you currently under physician care?  Y  N If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Y  N If yes, five approximate date(s) \_\_\_\_\_

Have you ever take Fen-Phen/redux?  Y  N

**Women:** Are you pregnant?  Y  N Nursing?  Y  N

Taking birth control pills?  Y  N

**Check (✓) yes or no whether you have had any of the following:**

<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Cough, persistent	<input type="checkbox"/> Jaw pain	<input type="checkbox"/> Shingles
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Cough up blood	<input type="checkbox"/> Kidney disease or malfunction	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Skin rash
<input type="checkbox"/> Arthritis, Rheumatism	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Material allergies (latex, wool, metal, chemicals)	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Artificial heart valves	<input type="checkbox"/> Fainting	<input type="checkbox"/> Mitral valve prolapse	<input type="checkbox"/> Stroke
<input type="checkbox"/> Artificial joints	<input type="checkbox"/> Food allergies	<input type="checkbox"/> Nervous problems	<input type="checkbox"/> Surgical implant
<input type="checkbox"/> Asthma	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Pacemaker/Heart surgery	<input type="checkbox"/> Swelling of feet or ankles
<input type="checkbox"/> Atopic (allergy prone)	<input type="checkbox"/> Headaches	<input type="checkbox"/> Psychiatric care	<input type="checkbox"/> Thyroid disease or malfunction

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Back problems        | <input type="checkbox"/> Heart murmur                  | <input type="checkbox"/> Rapid weight gain or loss | <input type="checkbox"/> Tobacco habit    |
| <input type="checkbox"/> Blood disease        | <input type="checkbox"/> Heart Problems                | <input type="checkbox"/> Radiation treatment       | <input type="checkbox"/> Tonsillitis      |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Describe                      | <input type="checkbox"/> Respiratory disease       | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Chemical dependency  | <input type="checkbox"/> Hemophilia/ abnormal bleeding | <input type="checkbox"/> Rheumatic/ Scarlet fever  | <input type="checkbox"/> Ulcer/Colitis    |
| <input type="checkbox"/> Chemotherapy         | <input type="checkbox"/> Herpes                        |  | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Circular problems    | <input type="checkbox"/> Hepatitis                     |  |   |
| <input type="checkbox"/> Cortisone treatments | <input type="checkbox"/> High blood pressure           |  |   |

Is patient currently taking any medications? \_\_\_\_\_ If yes, list all: \_\_\_\_\_

Does patient have drug allergies? \_\_\_\_\_ If yes, list all: \_\_\_\_\_

### **AUTHORIZATION**

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature                      Date

*Payment is due in full at time of treatment, unless prior arrangements have been approved.*