WELCOME

1 one — ABOUT YOU

Today's Date: ………/……../…….. File #:…………………
Patient Name:…………………………………………………..
LAST FIRST MI
What You Prefer To Be Called:…….. ☐ Male ☐ Female
Birthdate: ……/……./…….. Age:…….. SS#:……………………
Mailing Address: ………………………………………………..
……………………………………………………………………
CITY STATE ZIP
Home Phone #: (………….)…………………………………..
Work Phone #: (………….)………………….Ext:……………
Cell Phone #: (……………)…………………………………….
Email Address: ……………………………………………......
Referred By: ……………………………………………………..
Employer: ………………………..How Long?......................
Employer's Address: …………………………………………
……………………………………………………………………
CITY STATE ZIP
Occupation: ……………………………………………………..
Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced
☐ Separated ☐ Widowed
Spouse's Name: ………………………………………………
Do you have children? ☐Yes ☐ No How many?………..

2 two — INSURANCE INFO

Primary Dental Insurance
Co. Name:…………………………………………………
Address: ……………………………………………………..
……………………………………………………………………
CITY STATE ZIP
Phone #: (………….)……………………………………
Insured's ID#: ……………………………………………
Group # (Plan, Local, or Policy #): ……………………
Insured's Name:……………………………………………
Relation:…………………Date of Birth:…./……/……...
Insured's Employer: ..……………………………….....

Secondary Dental Insurance
Co. Name: …………………………………………………..
Address: ……………………………………………………..
……………………………………………………………………...
CITY STATE ZIP
Phone #: (………….)……………………………………
Insured's ID#: ……………………………………………
Group # (Plan, Local, or Policy#): ……………………..
Insured's Name:……………………………………………..
Relation:…………………Date of Birth:…./……/………
Insured's Employer: ..……………………………….....

3 three — ACCOUNT INFO

Person ultimately responsible for account
Name:………………………………………………………...…
Relation::……………………………………………...........
Billing Address: …………………………………………..….
…………………………………………………………………......
CITY STATE ZIP
SS #: ……………………………………………………………
Drivers License #: ……………………………………………..
Work Phone #: (………….)………………………………
Payment method: ☐ Cash ☐ Check
………………………………………………… …..../……
☐ Credit card - Enter card # above (if accepted)

…………. I hereby authorize assignment of my insurance rights and
Initials benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office)

4 four — IN EVENT OF EMERGENCY

Whom shoud we contact?…………………………………
Relation ……………………………………………………
Home Phone #: (………)…………………………………..
Work Phone #: (………..). ………………………………
Cell Phone #: (………)……………………………………...
Who is your Medical Doctor?……………………………...
Medical Doctor Phone #: (.……...)………………………..

PLEASE CONTINUE ON BACK

five 5

DENTAL INFORMATION

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation
Are you in pain? ☐ No ☐ Yes How Long?……………………………………………
Please indicate ☑ any of the following problems:
☐ Discomfort, clicking or popping in jaw. ☐ Lost/Broken Filling(s) ☐ Stained teeth
☐ Red, swollen or bleeding gums. ☐ Teeth grinding ☐ Locking Jaw
☐ Sensitive tooth, teeth or gums. ☐ Ringing in Ears ☐ Bad breath
☐ Blisters/Sores in or around the mouth. ☐ Broken/Chipped tooth
☐ Other: ……………………………………………………………………………………
Do you require pre-medication? ☐ Yes ☐ No ☐ Don't know
Previous Dentist: ………………………………… (………)……………………………
Name Phone #
Last Dental exam:……/………/……… Last Dental X-rays:……../………/………
Times a day you brush?.................... Times a week you floss? ……………………………
What type of tooth brush bristles do you use? ☐ Soft ☐ Medium ☐ Hard
How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

six 6

MEDICAL HISTORY

What medications are you taking? ☐ Nerve pills ☐ Pain killers (including aspirin) ☐ Muscle relaxers
☐ Stimulants ☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Meds for Osteoporosis
☐ Other(s), please list:………………………………………………………………………………………………
Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) ☐ Yes ☐ No Phen-fen/Redux ☐ Yes ☐ No
Do you have or have you had any of the following diseases, medical conditions or procedures?

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

Please list any other surgeries or medical conditions you have or ever had:……………………………………………
………
Are you allergic to any of the following? ☐ Latex ☐ Penicillin / Amoxicillin ☐ Tetracycline ☐ Aspirin
☐ Dental Anesthetics ☐ Foods:…………………………………………☐ 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? ☐ No ☐ Yes/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 the time of visit, unless other arrangements have been made with the business 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 of any changes to the information I have provided.
Signature……………………………………………Date……/……./…….
☐ Adult Patient ☐ Parent or Guardian ☐ Spouse

UPDATE
(OFFICE USE)

……… ……../……../………
Initials Date
……………………………………
Comments

……… ……../……../………
Initials Date
……………………………………
Comments

……… ……../……../………
Initials Date
……………………………………
Comments

First Impression Forms, Inc. 1-800-99FORMS FORM# 2DGA2 Copyright ©2007