Date_____

Patient Information

Name_____ SS #_____
Last Name First Initial

Address_____
City_____ State_____ Zip Code_____

Home Phone_____Cell Phone_____Email_____

Sex □ M □ F Age___ Birthdate_____ □ Single □ Married □ Separated □ Divorced

Patient Employed by_____ Occupation_____

Business Address_____Business Phone_____

Whom were you referred from?_____

In case of emergency who should be notified?_____

Primary Insurance

Person responsible for account_____
Last name First Mi

Relation to patient_____Birthdate_____Soc.Sec.#_____

Address (if different from patient's)_____

City_____ State_____ Zip Code_____

Person responsible employed by_____ Occupation_____

Business Address_____ Business Phone_____

Insurance company_____

Contract #_____ Group #_____ Subscriber #_____

Is patient covered under additional insurance? □ Yes □ No

Secondary Insurance_____

Dental History

Reason for today's visit_____

Former Dentist_____

Address_____

Date of last dental care_____ Date of last dental x-rays_____

Mark (**X**) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Grinding teeth
- ☐ Sensitivity to hot
- ☐ Periodontal treatment
- ☐ Loose teeth/broken fillings
- ☐ Sensitivity to sweets
- ☐ Sores or growths in your mouth
- ☐ Sensitivity when biting
- ☐ Sensitivity to cold
- ☐ Food collecting between teeth

Do you currently or have you had Botox ☐ Yes ☐ No or Dermal Fillers ☐ Yes ☐ No
If Yes date of last treatment _____

Medical History

Physician's Name_____ Date of last visit_____

Have you had any serious illnesses or operations? ☐Yes ☐ No If yes, describe_____

Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Mark (**X**) if you have or have had any of the following:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artifical Heart Valves
- ☐ Artifical Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Heart Problems

Describe:_____
_____

- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Keloid
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Retin A
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Veneral Disease

Medications

List medications you are currently taking: _____

Any bad reaction to drugs/allergies?_____

I authorize my insurance company to pay to Dr. Powers or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____ Date_____