

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

Date		Patient I	nformati	o n	
Address	Date	Soc. Sec. #		Birthdate	
Address	Name	Firet Name	Initial Hom	e Phone	
Sex: M F Minor Single Married Long Term Partner Divorced Widowed Separated Employer Business Phone Business Address Occupation Who should we thank for referring you? In case of emergency, who should we contact? Phone Primary Insurance Person Responsible for Account Birthdate Soc. Sec. # Address Home Phone City State Zip Responsible Party Employed By Business Phone Business Address Unsurance Company Insurance Company Address Subscriber I.D. # Group # Add it ional Insurance Employed By Birthdate Soc. Sec. # Address Soc. Sec. # Address Occupation Insurance Company Employed By Business Phone Insurance Company Address Subscriber I.D. # Group # Address First Name Soc. Sec. # Address Home Phone City State Zip Business Phone Birthdate Soc. Sec. # Address Home Phone City State Zip Business Phone Birthdate Soc. Sec. # Address Home Phone City State Zip Insurance Company Address Home Phone City State Zip Business Phone Insurance Company Address					
Business Phone Business Address Occupation Who should we thank for referring you? In case of emergency, who should we contact? Phone Primary Insurance Person Responsible for Account Last Name Relationship to Patient Birthdate Soc. Sec. # Address Home Phone City State Zip Business Phone Business Address Occupation Insurance Company Insurance Company Insurance Company Address Subscriber I.D. # Group # Address Home Phone City State Insured Name Last Name Birthdate Soc. Sec. # Address Unotable Frist Name Frist Name Frist Name Frist Name Insured Name Relationship to Patient Birthdate Soc. Sec. # Home Phone City State Zip Insured Employed By Business Phone Insured Employed By Business Phone Insurance Company Insurance Company Insurance Company Business Phone Insured Employed By Business Phone Insurance Company Insurance Company Insurance Company Insurance Company Address	City	State	Zip E-ma	ail	
Business AddressOccupation	Sex: M F	Minor Single Married	☐ Long Term Partner ☐ □	Divorced Widowed Sepa	arated
In case of emergency, who should we contact?	Employer		Business Phone		
Primary Insurance Company Primary Insurance Company Primary Insurance Company Address Print Marie Print Name	Business Address		Occupation		
Person Responsible for Account Relationship to Patient Birthdate Soc. Sec. # Address Home Phone City Responsible Party Employed By Business Phone Business Address Insurance Company Insurance Company Address Subscriber I.D. # Add it ional Insurance Priest Name Frest Name Frest Name Frest Name Frest Name Frest Name Institute Soc. Sec. # Address Home Phone City State Zip Business Phone Frest Name Institute Frest Name Frest Name Institute Soc. Sec. # Address Home Phone City State Zip Insured Employed By Business Phone Insured Employed By Insurance Company Insurance Company Address	Who should we thank for	referring you?			
Person Responsible for Account Relationship to Patient Birthdate Soc. Sec. # Home Phone City State Zip Responsible Party Employed By Business Phone Insurance Company Insurance Company Address Subscriber I.D. # Add it ional Insurance Company Insurance Name Relationship to Patient Birthdate First Name First Name Instial Address Home Phone City State Zip Business Phone Insurance Company Insurance Company Birthdate Soc. Sec. # Address Home Phone City State Zip Insurance Company Insurance Company Address	In case of emergency, wi	no should we contact?		_ Phone	
Relationship to Patient Birthdate Soc. Sec. #		Primary	Insuranc	е	
Relationship to Patient	Person Responsible for A	ccount			
City State Zip	Relationship to Patient _				al
Responsible Party Employed By	Address		Home Phone		
Business AddressOccupation	City		State	Zip	
Insurance Company Address Subscriber I.D. # Group # Additional Insurance Company Insured Name First Name First Name Initial Relationship to Patient Birthdate Soc. Sec. # Address Home Phone City State Zip Insured Employed By Business Phone Insurance Company Address Insurance Company Address Subscriber I.D. # Insurance Company Address Insurance Company Insurance Company Address Insurance Company Insurance Comp	Responsible Party Emplo	ved By Business Phone			
Insurance Company Address Subscriber I.D. #	Business Address	Occupation			
A d d i t i o n a l l n s u r a n c e Insured Name Last Name Relationship to Patient Address Home Phone City Insured Employed By Insurance Company Insurance Company Insurance Company Address	Insurance Company				
Add itional Insurance Insured Name Last Name Relationship to Patient Address Home Phone City Insured Employed By Insurance Company Insurance Company Address Insurance Company Address	Insurance Company Addr	ess			
Insured Name	Subscriber I.D. #	Group #			
Relationship to Patient		Additiona	I Insurar	тсе	
Relationship to Patient Birthdate Soc. Sec. # Address Home Phone City State Zip Insured Employed By Business Phone Insurance Company	Insured Name				
CityStateZip Insurance Company Insurance Company Address		Last Name			
CityStateZip Insurance Company Insurance Company Address	Address		Home Phone		
Insurance Company Insurance Company Address					
Insurance Company Address					
	Insurance Company				
Subscriber I.D. # Group #	Insurance Company Addr	ess			
	Subscriber I.D. #	Group #			

PLEASE COMPLETE REVERSE SIDE

Form #4067

(0304)

	Dental Histor	y			
Former Dentiet	Data of Last V Davis				
Former Dentist	Date of Last X-Rays				
City, State	How Often Do You Floss				
Date of Last Dental Visit	How Often Do You Brus	n?			
Please check all that apply:					
Bad Breath	Loose Teeth or Broken Fillings	Sensitivity to Sweets			
Bleeding Gums	Orthodontic Treatment	Sensitivity When Biting			
Blisters on Lips or Mouth	Pain Around Ear	Frequent Headaches			
Finger Nail Biting	Periodontal Treatment	Jaw, Head or Neck Injuries			
Grinding Teeth	Sensitivity to Cold	Jaw Difficulty: Clicking and/or Pain			
Lip or Cheek Biting	Sensitivity to Heat	Tooth Pain			
M	ledical Histo	rv			
Physicianís Name		Date of Last Visit			
	Yes No 7 Have you had any	allergic reactions to the following:			
1. Are you currently under medical treatment?	?	Yes No			
Have you ever had any serious illnesses		s (eg. novocaine)			
or operations?		Antibiotics			
	T CHICITITY OF OUTC	Antibiotics			
3. Are you currently taking any medication?					
Please describe:		eping pills)			
ricase describe.					
4. Do you smoke?	8. (Women Only) Are				
5. Do you use alcohol, cocaine or other drugs	?	100.			
6. Do you wear contact lenses?					
6. Do you wear contact lenses?					
Please check all that apply:	Taking on at oona	0,5110.			
AIDS	Emphysema	Pacemaker			
Anemia	Epilepsy	Psychiatric Care			
Arthritis, Rheumatism	Fainting or Dizziness	Radiation Treatment			
Artificial Heart Valves	Glaucoma	Respiratory Disease			
Artificial Joints	Headaches	Rheumatic Fever			
Asthma	Heart Murmur	Scarlet Fever			
Back Problems	Heart Problems	Shortness of Breath			
Bleeding abnormally,	Hepatitis-Type	Sinus Trouble			
with extractions or surgery	Herpes	Skin Rash			
Blood Disease	High Blood Pressure	Stroke			
Cancer	HIV Positive	Swelling of Feet/Ankles			
Chemical Dependency	Jaundice	Swollen Neck Glands			
Chemotherapy	Jaw Pain	Thyroid Problems			
Chronic Fatigue Syndrome	Kidney Disease	Tonsillitis			
Circulatory Problems	Latex Sensitivity	Tuberculosis			
Congenital Heart Lesions	Liver Disease	Tumor or growth on head/neck			
Cortisone Treatments	Low Blood Pressure	Ulcer			
Cough - persistent or bloody	Mitral Valve Prolapse	Venereal Disease			
Diabetes	Nervous Problems				
Assig	nment and Re	elease			
The second secon					
I hereby authorize payment directly to		t paid by insurance, and for all services			
services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.					
	der or supplier of services in this office to release	the information required to secure the			
payment of benefits. I authorize the use of th	ns signature on an insurance submissions.				
Signature of Responsible Party		Date			