



"We make you want to smile"

# Welcome

## Patient Information

*Thank you for choosing our practice for your dental care. Please complete this form in ink. If you have any concerns, do not hesitate to ask for assistance. We will be happy to help.*

(Please Print)

Name \_\_\_\_\_ Email \_\_\_\_\_ Date \_\_\_\_\_

First MI Last

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birthdate \_\_\_\_\_ Home# \_\_\_\_\_ Work# \_\_\_\_\_ Cell# \_\_\_\_\_

Do you prefer to receive calls at:  Home  Work  Either

Are you:  Minor  Married  Divorced  Widowed  Single

Your or your parent's employer \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse's or parents name \_\_\_\_\_ Workplace \_\_\_\_\_ Work# \_\_\_\_\_

If you are a student, name of school/college \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Phone # \_\_\_\_\_

## Responsible Party

Name of person responsible for this account: \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of employer \_\_\_\_\_ Work # \_\_\_\_\_

## Insurance Information

Name of insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of employer \_\_\_\_\_ Work # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ Employer # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

DO YOU HAVE ADDITIONAL INSURANCE?  No  Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of employer \_\_\_\_\_ Work Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ Employer # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

# Dental History

Name \_\_\_\_\_ Age \_\_\_\_\_

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

Reason for today's visit \_\_\_\_\_

Date of last exam \_\_\_\_\_ How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

Are you satisfied with the appearance of your front teeth? \_\_\_\_\_

Please check any of the following conditions that apply to you:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Bad Breath                    | <input type="checkbox"/> Grinding Teeth              | <input type="checkbox"/> Sensitivity to hot       |
| <input type="checkbox"/> Bleeding Gums                 | <input type="checkbox"/> Loose Teeth/Broken Fillings | <input type="checkbox"/> Sensitivity to sweets    |
| <input type="checkbox"/> Clicking or Popping Jaw       | <input type="checkbox"/> Periodontal treatment       | <input type="checkbox"/> Sensitivity when biting  |
| <input type="checkbox"/> Food Collection Between Teeth | <input type="checkbox"/> Sensitivity to cold         | <input type="checkbox"/> Sore or growths in mouth |

# Medical History

Physician \_\_\_\_\_ Date of last visit \_\_\_\_\_

Please list all medications you are currently taking \_\_\_\_\_

Allergies \_\_\_\_\_

(Women) Are you pregnant?  Yes  No Nursing?  Yes  No Taking birth control pills  Yes  No

Do you have a history with any of the following?

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> AIDS                    | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Rheumatic Fever           |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cough, Persistent    | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Scarlet Fever             |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Cough up blood       | <input type="checkbox"/> HIV Positive          | <input type="checkbox"/> Shortness of Breath       |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Skin Rash                 |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Stroke                    |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Swelling of Feet or Ankle |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems          |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Nervous Problems      | <input type="checkbox"/> Tobacco Habit             |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tonsillitis               |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Tuberculosis              |
| <input type="checkbox"/> Chemotherapy            | Describe _____                                | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Ulcer                     |
| <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Venereal Disease          |

# Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any and all information about my dental care to third party payers or health care providers. I authorize and request my insurance company to pay directly to the dentist benefits otherwise payable to me. I understand that it is my responsibility to obtain and understand my insurance or benefits and do not hold Dr. Shuster or his staff responsible for this. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I further agree to pay all finance charges, collection costs, attorneys fees, and any other costs that may be incurred to enforce collection of any amount outstanding.

X

\_\_\_\_\_  
SIGNATURE OF PATIENT (Or parent if minor)

CONFIDENTIAL