PATIENT INFORMATION

Today's Date _____ Sex: ☐ M ☐ F

Patient Name _____ Date of Birth _____
Last First M.I.

Address _____ City _____ State _____ Zip _____

Cell/Home Phone _____ E-mail _____

Employer/School _____ Employer/ School Phone _____

Who may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

Name of Person Responsible _____ Relation to Patient _____

Address _____ Home/Cell Phone _____

Employer _____ Work Phone _____

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____ Birthdate _____

Social Security # _____ Employer _____ Work Phone _____

Insurance Company _____ Subscriber ID _____ Group ID _____

Claim Address _____ Insurance Phone Number _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____ Birthdate _____

Social Security # _____ Employer _____ Work Phone _____

Insurance Company _____ Subscriber ID _____ Group ID _____

Claim Address _____ Insurance Phone Number _____

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care/X-rays _____

Former Dentist _____ Address/Phone Number _____

Check box if you have had problems with any of the following:

☐ Bad breath	☐ Food Collection between teeth	☐ Periodontal treatment	☐ Sensitivity to sweets
☐ Bleeding Gums	☐ Grinding or Clenching Teeth	☐ Sensitivity to cold	☐ Sensitivity when biting
☐ Clicking of popping jaw	☐ Loose teeth or broken fillings	☐ Sensitivity to hot	☐ Sores/growths in your mouth

How often do you floss? _____ How often do you brush? _____

Would you like to change the way your teeth look? _____ Have you had gum surgery? _____

Have you ever had nitrous oxide (laughing gas) when you had dental care? _____

Have you had bad experiences in dental offices? _____

Are you nervous about dental care? (We have many ways to make things easier) _____

MEDICAL HISTORY

Physician's Name _____ Phone _____ Date of Last Visit _____

Have you ever had any serious illnesses or operations? (If yes, describe) _____

Have you ever had a blood transfusion? Yes ☐ No ☐ If yes, give approximate date _____

(Women) Are you pregnant? Yes ☐ No ☐ If yes, which trimester? _____

Check box if you have had problems with any of the following:

☐ Anemia	☐ Chemotherapy	☐ Heart Problems	☐ Pacemaker	☐ Stroke
☐ Arthritis, Rheumatism	☐ Circulatory Problems	☐ Hemophilia	☐ Radiation Treatment	☐ Swelling of Feet/Ankles
☐ Artificial Heart Valves	☐ Cortisone Treatments	☐ Hepatitis (Type ___)	☐ Respiratory Disease	☐ Thyroid Problems
☐ Artificial Joints	☐ Diabetes	☐ High Blood Pressure	☐ Rheumatic Fever	☐ Tobacco Habit
☐ Asthma	☐ Epilepsy	☐ HIV/AIDS	☐ Scarlet Fever	☐ Tuberculosis
☐ Back problems	☐ Fainting	☐ Kidney Disease	☐ Shortness of Breath	☐ Ulcer
☐ Cancer	☐ Headaches	☐ Liver Disease	☐ Sleep Apnea	☐ Other: _____
☐ Chemical Dependency	☐ Heart Murmur	☐ Low Blood Pressure	☐ Snoring	

MEDICATIONS

List any medications you are currently taking:

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

Check boxes if you have allergies to the following:

☐ Latex ☐ Sulfa

☐ Codeine ☐ Penicillin

☐ Local Anesthetic ☐ Other _____

SIGNATURE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Katherine Hicks all insurance benefits, if any, otherwise payable to me
(Name of Insurance Company)
for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. I authorize the dental staff to perform any necessary dental services, with my informed consent, that I may need during diagnosis and treatment.

_____ _____

Signature of Patient, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Guardian or Personal Representative — Relationship to Patient