

# Welcome

*We are pleased to welcome you to Dr. Carlson's. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.*

## Patient information

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Sex M or F : Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Single, Married, Widowed, Separated, Divorced

Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business phone \_\_\_\_\_

Whom may we thank for referring you: \_\_\_\_\_

Notify in case of emergency \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell phone \_\_\_\_\_

**Dependant Children:** must be accompanied by a parent or guardian. Adult accompanying child to dental appointment is responsible for payment at the time of visit unless prior arrangements have been made.

## Primary Insurance

Name \_\_\_\_\_ Soc. Sec # \_\_\_\_\_

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Employer \_\_\_\_\_ Insurance Carrier \_\_\_\_\_

Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_ Phone \_\_\_\_\_

## Secondary Insurance

Name \_\_\_\_\_ Soc. Sec # \_\_\_\_\_

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Employer \_\_\_\_\_ Insurance Carrier \_\_\_\_\_

Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_ Phone \_\_\_\_\_

What would you like us to do today? \_\_\_\_\_

Are you in dental discomfort today? \_\_\_\_\_

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

Date of last dental Visit \_\_\_\_\_ Reason: \_\_\_\_\_

Date of last x-rays \_\_\_\_\_

Check Y for yes or N for no if you have or have not had the following:

Y or N Bad breath

Y or N Food collection between teeth

Y or N Periodontal treatment

Y or N Sensitivity to sweets

Y or N Bleeding gums

Y or N grinding or clenching teeth

Y or N Sensitivity to cold

Y or N Sensitivity when biting

Y or N Clicking or Popping jaw

Y or N Sensitivity to hot

Y or N sores or growths in mouth

Y or N Loose teeth/ broken fillings

How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

How do you feel about the appearance of your teeth? \_\_\_\_\_

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental Procedure? \_\_\_\_\_

### Medical History

Primary Physician's name \_\_\_\_\_ Phone \_\_\_\_\_ Date of last visit \_\_\_\_\_

Specialist name \_\_\_\_\_ Phone \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you had any serious illnesses or operations? Y or N if yes describe \_\_\_\_\_

Are you currently under a physicians care? Y or N if yes describe \_\_\_\_\_

Have you ever had a blood transfusion? Y or N if yes, give approx dates \_\_\_\_\_

Have you ever taken Fen-Phen/Redux? Y or N

Have you ever taken or been told you needed to take an antibiotic for Dental treatment? Y or N

Women: Are you pregnant? Y or N Nursing? Y or N Taking birth control pills? Y or N

Check Y for yes or N for no if you have or have not had the following:

Y or N AIDS/HIV Positive

Y or N Cough, persistent

Y or N Jaw pain

Y or N Shingles

Y or N Anaphylaxis

Y or N Cough up blood

Y or N Kidney disease or

Y or N Shortness of breath

Y or N Anemia

Y or N Diabetes

malfunction

Y or N Skin rash

Y or N Arthritis, Rheumatism

Y or N Epilepsy

Y or N Liver disease

Y or N Spina Bifida

Y or N Artificial heart valves

Y or N Fainting

Y or N Material allergies (latex,

Y or N Stroke

Y or N Artificial joints

Y or n Food allergies

wool, metal, chemicals)

Y or N Surgical implant

Y or N Asthma

Y or N Glauoma

Y or N Mitral valve prolapse

Y or N Swelling of feet or ankles

Y or N Atopic (allergy prone)

Y or N Headaches

Y or N Nervous problems

Y or N Thyroid disease or

Y or N Back problems

Y or N Heart murmur

Y or N Pacemaker/Heart surgery

malfunction

Y or N Blood disease

Y or N Heart problems

Y or N Psychiatric care

Y or N Tobacco habit

Y or N Cancer

Y or N Hemophilia/Abnormal

Y or N Rapid weight gain or loss

Y or N Tuberculosis

Y or N Chemical dependency

bleeding

Y or N Radiation treatment

Y or N Ulcer/Colitis

Y or N Chemotherapy

Y or N Herpes

Y or N Respiratory disease

Y or N Venereal disease

Y or N Circulatory problems

Y or N Hepatitis

Y or N Rheumatic fever

Y or N Cortisone treatment

Y or N High blood pressure

Y or N Scarlet fever

List Medications you are currently taking, If any:

List drug allergies, if any:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize my insurance company to pay to the dentist 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 authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Payment is due in full at time of treatment unless prior arrangements have been approve.**