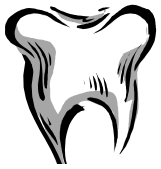
Welcome



DATE: _____ ***PATIENT INFORMATION***

Name: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. _____ _____ _____
Last Name First Name Initial

Home Phone: _____ Cell Phone: _____ Email: _____

Soc. Sec. # _____ Sex: ☐ M ☐ F Age: _____ Birthdate: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Employer Address: _____ Work Phone: _____

City: _____ State: _____ Zip: _____

In case of emergency, who should be notified? _____ Phone: _____

Whom may we thank for referring you? _____ Hobbies: _____

PRIMARY DENTAL INSURANCE

Primary person insured: _____ _____ _____
Last Name *First Name* *Initial*

Relation to Patient: _____ Birthdate of insured _____ Phone: _____

Address (if different from patient's) _____

City: _____ State: _____ Zip: _____

Employer of Person Responsible: _____ Occupation: _____

Employer Address: _____ Business Phone: _____

City: _____ State: _____ Zip: _____

Insurance Company: _____ Group # _____ Subscriber (Soc. Sec. #) _____

Address: _____ City: _____ State: _____ Phone: _____

ADDITIONAL DENTAL INSURANCE

Subscriber name: _____ Relation to Patient: _____ Birthdate: _____

Address (if different from patient's) _____

City: _____ State: _____ Zip: _____

Subscriber Employer Address: _____ Business Phone: _____

City: _____ State: _____ Zip: _____

Insurance Company: _____ Group # _____ Subscriber (Soc. Sec. #) _____

Address: _____ City: _____ State: _____ Phone: _____

OVER ➔

DENTAL HISTORY

Reason for Today's visit: _____

Former Dentist: _____

Date of last dental visit: _____ Date of last dental x-rays: _____

Check (✓) if you have/had any of the following:

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

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

MEDICAL HISTORY

Physician's Name: _____

Have you had any serious illness or operations? ☐ Yes ☐ No If yes, describe _____

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

(Women Only ☺) Are you pregnant? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have/had any of the following:

☐ AIDS
☐ Anemia
☐ Arthritis, Rheumatism
☐ Artificial Heart Valves
☐ Asthma
☐ Back Problems
☐ Cancer
☐ Chemical Dependency
☐ Chemotherapy
☐ Circulatory Problems
☐ Cortisone or other steroid therapy
☐ Cough, Persistent
☐ Cough up blood
☐ Diabetes
☐ Fainting
☐ Glaucoma
☐ Headaches
☐ Heart Murmur
☐ Heart Problems
☐ Hemophilia
☐ Hepatitis Type: _____
☐ High Blood Pressure
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Seizures
☐ Shortness of breath
☐ Skin Rash
☐ Stroke
☐ Swelling of Feet or Ankles
☐ Thyroid Problems
☐ Tobacco Habit
☐ Tonsillitis
☐ Tuberculosis
☐ Venereal Disease
☐ Other, Please list
_____
_____
_____
_____

Do you smoke? ☐ Yes ☐ No Have you ever smoked? ☐ Yes ☐ No

If yes, what do you smoke? _____ How many a day? _____ For how long? _____

Do you use chewing tobacco? ☐ Yes ☐ No Have you ever used chewing tobacco? ☐ Yes ☐ No

MEDICATIONS:

List medications you are currently taking: _____

_____

List any medications you are allergic to: _____

AUTHORIZATION

I understand that I am solely and financially responsible for 100% of services provided. I understand that payment is due in full at time of treatment unless Dr. Israelson has approved prior arrangements.

Signature: _____ Date: _____

FOR DENTAL INSURED PATIENTS ONLY

I authorize my insurance company to pay Dr. Israelson all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize Dr. Israelson to release all information necessary to secure the payment of benefits. I agree to pay any estimated amount not to be paid by insurance on day of treatment and understand that this is only an estimate. I understand insurance may not pay 100% for all procedures and that I am 100% responsible for any amount not paid by insurance.

Signature: _____ Date: _____