Welcome

New Patient Information

For Office Use

Chart No.

_____

Name:_____ Date of Birth:_____ Sex: M / F

First MI Last Month/Day/Year

Address:_____

Street City State Zip

Phone:_____ _____ _____

Home Cell Work

Email:_____ May we contact you by email? Y / N

Social Security #:_____ Drivers' License #:_____

How did you hear about Dogwood Dentistry? _____

Responsible Party for Payment:_____ Phone:_____

Do you have Dental Insurance: Y / N		Do you have secondary Dental Insurance? Y / N	
Primary Insurance		Primary Insurance	
Subscriber Name		Subscriber Name	
Subscriber ID		Subscriber ID	
Date of Birth		Date of Birth	
Relationship to Subscriber		Relationship to Subscriber	
Employer Name		Employer Name	
Employer Phone		Employer Phone	
Insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	
Insurance Phone #		Insurance Phone #	
*Please present insurance card to receptionist to be copied			

Assignment of Benefits:

I authorize payment directly to Dogwood Dentistry for all insurance benefits otherwise payable to me for 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 dependents. I authorize Dogwood Dentistry to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of Responsible Party Date

Welcome

Dental/Medical Information

For Office Use

Chart No. _____

Dental History

Reason for todays visit:_____ Date of last dental visit: _____

Previous Dentist: _____ Date of last dental x-rays:_____

Please check (✓) have or have had any of the following:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking/Popping Jaw
- ☐ Food sticks between teeth
- ☐ Grinding teeth
- ☐ Loose teeth
- ☐ Broken Fillings
- ☐ Periodontal Treatment
- ☐ Sensitivity (Hot/Cold)
- ☐ Sensitivity (Sweets)
- ☐ Sensitivity (Biting)
- ☐ Sores or Growths in Mouth

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

Medical History

Physician's Name: _____ Date of last visit:_____

Have you ever had any serious illness or operation? Y / N

If yes, describe_____

Have you ever had a blood transfusion? Y / N

If yes, give approximate dates: _____

Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking Birth Control? ☐Yes ☐No

Please check (✓) have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joint, Pin, etc. _____
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormality
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough (Persistent)
- ☐ Cough (Bloody)
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hernia Repair
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Use
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

List medications you are currently taking:

_____ _____
_____ _____
_____ _____
_____ _____

Allergies:

_____ _____
_____ _____
_____ _____
_____ _____