



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: _____

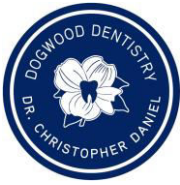
Do you have Dental Insurance: Y / N		Do you have secondary Dental Insurance? Y / N	
Primary Insurance		Primary Insurance	
Subscriber Name		Subscriber Name	
Subscriber ID		Subscriber ID	
Date of Birth		Date of Birth	
Relationship to Subscriber		Relationship to Subscriber	
Employer Name		Employer Name	
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 today's visit: _____

Date of last dental visit: _____

Previous Dentist: _____

Date of last dental x-rays: _____

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

- | | | |
|--|--|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity (Hot/Cold) |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Sensitivity (Sweets) |
| <input type="checkbox"/> Clicking/Popping Jaw | <input type="checkbox"/> Broken Fillings | <input type="checkbox"/> Sensitivity (Biting) |
| <input type="checkbox"/> Food sticks between teeth | <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> 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:

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

List medications you are currently taking:

Allergies:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____