

Patient Information (Confidential)

Patient Name: _____ Date of Birth: _____
Last First

Emergency Contact: _____

Preferred Hospital: _____

Health Information

Have you ever had any of the following? Please check those that apply:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> AIDS/HIV Infection | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Allergies/Hay Fever | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Heart Troubles |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Arthritis/ Rheumatism | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Tumors | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problem | Have you taken: |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Phen-Fen |
| <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Redux |
| <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Chest Pains | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Heart Attack | |
| <input type="checkbox"/> Frequently Tired | <input type="checkbox"/> STD | <input type="checkbox"/> Heart Disease | |

• **Women Only:** Please check all that apply: Pregnant/Due Date _____ Nursing Taking oral contraceptives

• **Are you allergic to or have any reactions to the following?** None Penicillin or any other antibiotic
 Sulfa Drugs Barbiturates Sedatives Iodine Aspirin Any metals (e.g. nickel, mercury, etc.)
 Latex Other : (please list) _____

• Are you currently taking any medications (including herbal medicines or food supplements)? Yes No
If yes, please list all _____

• Do you use any of the following tobacco products? Cigarettes Pipe or Cigar Dip or Chew None

• Are you under medical treatment or under the care of a physician now? Yes No
If yes, please explain: _____

• Physician Name _____ Phone Number _____ Last Exam _____

• Have you been admitted to a hospital or needed emergency care during the past five years? Yes No

Patient Dental History

Name and Location of Previous Dentist _____ Date of Last Exam _____

Please check all that apply:

<input type="checkbox"/> Bleeding gums while brushing or flossing
<input type="checkbox"/> Sensitive to hot, cold, sweet, sour liquids/foods
<input type="checkbox"/> Bite lips or cheeks frequently
<input type="checkbox"/> Frequent headaches
<input type="checkbox"/> Clench or grind your teeth
<input type="checkbox"/> Difficult extractions in the past
<input type="checkbox"/> Prolonged bleeding following extractions
<input type="checkbox"/> Head, neck or jaw injuries
<input type="checkbox"/> Had orthodontic treatment

<input type="checkbox"/> Have sores or lumps near or in your mouth
<input type="checkbox"/> Eat or drink five or more meals per day
<input type="checkbox"/> Chew sugar free gum
<input type="checkbox"/> Eat mints, candies, cookies, chips, crackers between meals
<input type="checkbox"/> Drink sweetened beverages between meals
<input type="checkbox"/> Drink milk or eat cheese everyday
<input type="checkbox"/> Received oral hygiene instructions regarding the care of your teeth
<input type="checkbox"/> Wear dentures or partials If yes, date of placement: _____
<input type="checkbox"/> Feel pain in any of your teeth

• Have you ever experienced any of the following (**please check all that apply**): Problems in your jaw Clicking
• Pain (joint, ear, side of face) Difficulty in opening or closing Difficulty in chewing

• Do you like your smile? Yes No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Date: _____

Signature of patient, parent or guardian _____

Welcome

*Thank you for selecting our dental health care team.
We strive to provide you with the best possible dental care. To help us
meet all of your dental healthcare need, please fill out this form completely
in ink. If you need any assistance, please ask us, we will be happy to help.*

Patient Information (Confidential)

Name: _____ Date: _____
Last Name First Name MI

Status: _____ Birth Date: _____ Social Security #: _____ Drivers License: _____

Address: _____
Street Apartment #

_____ City State Zip Code

E-Mail: _____ Phone (Home): _____ (Work): _____ Ext: _____

(Cell Phone): _____ (Pager): _____ (Fax): _____

Employer: _____

Whom may we thank for referring you to our practice? _____

For your convenience, we offer the following methods of payment. Please check the option you prefer.
Payment is due in full at each appointment. Cash Personal Check Credit Card I wish to discuss payment policy

Check box if same as above

Responsible Party Information

Name: _____
Last Name First Name MI

Status: _____ Birth Date: _____ Social Security #: _____ Drivers License: _____

Address: _____
Street Apartment #

_____ City State Zip Code

E-Mail: _____ Phone (Home): _____ (Work): _____ Ext: _____

(Cell Phone): _____ (Page): _____ (Fax): _____

Employer: _____

Insurance Information

Primary

Name of Insured: : _____ Relationship to patient: _____
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Insurance Plan Name and Address: _____
Phone: _____

Secondary

Name of Insured: _____ Relationship to patient: _____
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____
Address: _____
Street City State Zip Code

Insurance Plan Name and Address: _____
Phone: _____

Acknowledgement Form

Patient Name: _____ Date of Birth: _____
Last First

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent if minor)

Date

Educational Release

Dr. Watkins teaches continuing education courses to other dentist. I authorize the release of my photographs of clinical conditions to be used by Dr. Watkins in his lectures. **Accepts** **Declines**

X _____

Signature of patient (or parent if minor)

Acknowledgement of Receipt of Privacy Practices ****You May Refuse to Sign This Acknowledgement****

I, _____, have had the opportunity to review or have received a copy of this office's Notice of Privacy Policy

_____ Date: _____ Relationship to Patient: _____

Signature of patient (or parent if minor)