Patient Welcome Form

Patient Information

Adult/Child: ______________ Date: ______________

Last Name: ______________________ First Name: ______________________ MI: ______

Gender (Male/Female): __________ Email: ______________________ Birthdate: __________

Marital Status (Single/Married/Divorced/Widower): ______________________________

Driver's License #: ______________________ S.S.# ______________________________

Address: ______________________________________ Apt./Condo #: ______________

City: ______________________ State: ____________ Zip Code: __________________

Home Phone: ______________________ Mobile Phone: ________________________

Occupation: ______________________ Work Phone: ___________________________

When and where are the best times to contact you? _____________________________

Guarantor

if the patient is a minor, do you have legal custody? __________

Relationship to Patient (Spouse/Parent/Tutor/Legal Guardian/Other): ______________________

Last Name: ______________________ First Name: ______________________ MI: ______

Gender (Male/Female): __________ Email: ______________________ Birthdate: __________

Marital Status (Single/Married/Divorced/Widower): ______________________________

Driver's License #: ______________________ S.S.# ______________________________

Address: ______________________________________ Apt./Condo #: ______________

City: ______________________ State: ____________ Zip Code: __________________

Home Phone: ______________________ Mobile Phone: ________________________

Occupation: ______________________ Work Phone: ___________________________

When and where are the best times to contact you? _____________________________

Emergency Contact

in case of emergency please provide the following information:

Name: ______________________________ Relationship: ______________________

Work Phone: ______________________ Home/Mobile Phone: ______________________

How did you hear about us?:

Yellow Pages	Internet	Yelp
Family/Friend	Flyer/Mail	Facebook
Event	Outside Sign/Balloon	Other
Radio	Mobile Ad	
TV	My Insurance Plan	

Payment Options:

Insurance	Ùonrisa Dental Plaȷ
Cash/ Check	Ô¦^åit/Ö^àãáÔaeå

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Dental History

Why have you come to the dentist today?: ______________________________

Are you currently in pain?(Yes/No): ______________________________

Have you ever had a problem with any previous dental work? (Yes/No): ______________________________

Do your gums bleed? (Yes/No): ______________________________

How many times a week do you brush?: ______________________________

How many times a week do you floss?: ______________________________

Medical History

Personal Physicians Name: ______________________________ Phone Number:______________________________

Date of Last Visit: ______________ Your current health is (Good/Regular/Poor): ______________________

Are you currently under the care of a physician? (Yes/No): ______________________________

Please explain: ______________________________

Are you taking any prescription/over the counter drugs? (Yes/No): ______________________________

Please list each one: ______________________________

Do you smoke tobacco in any way? (Yes/No): ______________________________

Do you have or have you ever had any of the following?

Please select all that apply:

- Abnormal Bleeding
- AIDS, HIV+
- Alcohol or Drug Abuse
- Anemia
- Arthritis
- Artificial Bones/Joints/Valves
- Asthma
- Blood Transfusion
- Cancer, Chemotherapy
- Colitis
- Congenital Heart Defect
- Diabetes
- Difficulty Breathing
- Epilepsy
- Fainting Spells
- Frequent Headaches
- Glaucoma
- Hay Fever
- Heart Attack
- Heart Surgery
- Heart Murmur
- Hemophilia
- Hepatitis
- Herpes, Fever Blisters
- High Blook Pressure
- Kidney Problems
- Liver Disease
- Low Blood Pressure
- Lupus
- Mitral Valveprolapse
- Pacemaker
- Psychiatric Problems
- Radiation Treatment
- Rheumatic; Scarlet Fever
- Seizures
- Shingles
- Sickle Cell Disease
- Sinus Problems
- Stroke
- Thyroid Problems
- Tuberculosis
- Ulcers

Are you allergic to any of the following?

Please select all that apply:

- Aspirin
- Codeine
- Dental Anesthetics
- Penicillin
- Erythromycin
- Latex
- Jewelry
- Tetracycline

For women:

Are you taking birth control pills?__________

Are you pregnant?:______________________

Week #:______________________________

Are you nursing?: ______________________

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Agreement:

I acknowledge that this information is correct and will be held in the strictest confidence.
I authorize Jefferson Dental Clinics to contact me regarding promotions and services.
I authorize Jefferson Dental Clinics to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. Payment is due in full at the time of treatment unless prior arrangements have been approved. I understand that I am responsible for paying any copayment and deductibles that my insurance does not cover. I hereby authorize payment directly to Jefferson Dental Clinics of the group insurance benefits otherwise payable to me. I hereby authorize release of any information including the diagnosis and records of treatment or examination rendered, to my insurance company. Please type your full first and last name and date to represent your signature. You may also sign this form once you arrive to the office for your appointment.

Signature:______________________________________ Date: ____________________

Office Use Only:

I verbally reviewed the medical/dental information above with the patient named herein.

Initials: _____________________ Date:__________________

Doctor's comments: ____

UPDATE:

Comment: ____

Signature:______________________________________ Date: ____________________

Comment: ____

Signature:______________________________________ Date: ____________________