WELCOME TO SOUTH WASHINGTON DENTAL

Please take a few minutes to answer the following questions so
We can better assist you with your dental needs.

PATIENT INFORMATION

Date _____ **Soc. Sec. #** _____ **Birthday**_____

Name _____ **Home Phone** _____
Last Name First Name Initial

Address _____ **Cell Phone** _____

City _____ **State** _____**Zip** _____ **E-mail**_____

Sex ☐**M** ☐**F** ☐**Minor** ☐**Single** ☐**Married** ☐**Long Term Partner** ☐**Divorced** ☐ **Widowed** ☐ **Separated**

Employer _____ **Business Phone** _____

Business Address _____ **Occupation** _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ **Phone** _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ **Birthday** _____ **Soc. Sec. #** _____

Address _____ **Home Phone** _____

City _____ **State** _____ **Zip** _____

Responsible Party Employed by _____**Business Phone** _____

Business Address _____ **Occupation** _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ **Group #** _____

ADDITIONAL INSURANCE (IF APPLICABLE)

Insured Name _____
Last Name First Name Initial

Relationship to Patient _____ **Birthday** _____ **Soc. Sec. #** _____

Address _____ **Home Phone** _____

City _____ **State** _____ **Zip** _____

Insured Employed by_____ **Business Phone** _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ **Group #** _____

PLEASE COMPLETED REVERSE SIDE

DENTAL HISTORY

Former Dentist _____ **Date of Last X-Rays**_____

City, State _____ **How Often Do You Floss?** _____

Date of Last Dental Visit _____ **How Often Do You Brush?** _____

Please check all that apply:

Bad Breath ..... ☐	Loose Teeth or Broken Fillings..... ☐	Sensitivity to Sweets ..... ☐
Bleeding Gums ..... ☐	Orthodontic Treatment ..... ☐	Sensitivity When Biting ..... ☐
Blisters on Lips or Mouth ..... ☐	Pain around Ear..... ☐	Frequent Headaches ..... ☐
Finger Nail Biting..... ☐	Periodontal Treatment..... ☐	Jaw, Head or Neck Injuries ..... ☐
Grinding Teeth ..... ☐	Sensitivity to Cold..... ☐	Jaw Difficulty: Clicking and/or Pain..... ☐
Lip or Cheek Biting ..... ☐	Sensitivity to Heat..... ☐	Tooth Pain ..... ☐

MEDICAL HISTORY

Physician Name _____ **Date of the Last Visit** _____

	Yes	No
1. Are you currently under medical treatment	☐	☐
2. Have you ever had any serious illnesses or operations?...	☐	☐
3. Are you currently taking any medication?	☐	☐
Please describe: _____		
_____		
4. Do you smoke?.....	☐	☐
5. Do you use alcohol, cocaine or other drugs?.....	☐	☐
6. Do you wear contact lenses?.....	☐	☐

7. Have you had any allergic reaction to the following?

	Yes	No
Local Anesthetic (e.g. Novocaine).....	☐	☐
Penicillin or other Antibiotics.....	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills).....	☐	☐
Sedatives.....	☐	☐
Iodine.....	☐	☐
Aspirin.....	☐	☐
8. (Women only) Are you Pregnant?.....	☐	☐
Nursing?..... .	☐	☐
Taking birth control pills?.....	☐	☐

Please check all that apply:

AIDS..... ☐	Cortisone Treatments..... ☐	Latex Sensitivity..... ☐	Swollen Neck Glands..... ☐
Anemia..... .... ☐	Cough-persistent or bloody... ☐	Liver Disease ..... ☐	Tyrode Problems..... ☐
Arthritis Rheumatism..... ☐	Diabetes..... ☐	Low Blood Pressure..... ☐	Tonsillitis..... ☐
Artificial Heart Valves..... ☐	Emphysema..... ☐	Mitral Valve Prolapse ..... ☐	Tuberculosis..... ☐
Artificial Joints..... ☐	Epilepsy..... ☐	Nervous Problem..... ☐	Tumor or grown on Head
Asthma..... ☐	Fainting or Dizziness..... ☐	Pacemaker..... ☐	or Neck..... ☐
Back Problems..... ☐	Glaucoma..... ☐	Psychiatric Care..... ☐	Ulcer..... ☐
Bleeding abnormally with	Headaches..... ☐	Radiation Treatment..... ☐	Venereal Disease..... ☐
extractions or surgery..... ☐	Heart Murmur..... ☐	Respiratory Disease..... ☐	**Other** _____
Blood Disease..... ☐	Hepatitis – Type _____..... ☐	Rheumatic Fever..... ☐	_____
Cancer ..... ☐	Herpes..... ☐	Scarlet Fever..... ☐	_____
Chemical Dependency..... ☐	High Blood Pressure..... ☐	Shortness of Breath..... ☐	_____
Chemotherapy..... ☐	HIV Positive..... ☐	Sinus Trouble..... ☐	
Chronic Fatigue Syndrome... ☐	Jaundice..... ☐	Skin Rash..... ☐	
Circulatory Problems..... ☐	Jaw Pain..... ☐	Stroke..... ☐	
Congenital Heart Lesions..... ☐	Kidney Disease..... ☐	Swelling of Feet or Ankles..... ☐	

Assignment and Release

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I financially responsible for all charges, whether or not paid by insurance and for all services rendered on my behalf or my dependents. I authorize the above doctor and /or any provider or supplier of services in this office 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** _____