Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date _____ Home Phone _____ E-Mail Address _____

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F . Age _____ Birth date _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you ? _____

In case of emergency who should be notified ? _____ Phone _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birth date _____ Soc. Sec. # _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____ Phone _____

Insurance Address _____ City _____ State _____ Zip _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No Subscriber Name _____

Relation to Patient _____ Birth date _____ Soc. Sec. # _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ Phone _____

Insurance Address _____ City _____ State _____ Zip _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Please Complete Both Pages

Dental History

Reason for Today's Visit _____

Former Dentist _____

Address _____

Date of last dental care _____ Date of last dental X-rays _____

Check Yes or No if you have any problems with the following:

Y	N		Y	N		Y	N	
☐	☐	Bad breath	☐	☐	Grinding teeth	☐	☐	Sensitivity to hot
☐	☐	Bleeding gums	☐	☐	Loose teeth or broken fillings	☐	☐	Sensitivity to sweets
☐	☐	Clicking or popping jaw	☐	☐	Periodontal treatment	☐	☐	Sensitivity when biting
☐	☐	Food collection between teeth	☐	☐	Sensitivity to cold	☐	☐	Sores or growths in your mouth

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

Medical History

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check Yes or No if you have any of the following:

Y	N		Y	N		Y	N		Y	N	
☐	☐	AIDS	☐	☐	Cortisone Treatments	☐	☐	Hepatitis	☐	☐	Rheumatic Fever
☐	☐	Anemia	☐	☐	Cough, Persistent	☐	☐	High Blood Pressure	☐	☐	Scarlet Fever
☐	☐	Arthritis, Rheumatism	☐	☐	Cough up Blood	☐	☐	HIV Positive	☐	☐	Shortness of Breath
☐	☐	Artificial Heart Valves	☐	☐	Diabetes	☐	☐	Jaw Pain	☐	☐	Skin Rash
☐	☐	Artificial Joints	☐	☐	Epilepsy	☐	☐	Kidney Disease	☐	☐	Stroke
☐	☐	Asthma	☐	☐	Fainting	☐	☐	Liver Disease	☐	☐	Swelling of Feet / Ankles
☐	☐	Back Problems	☐	☐	Glaucoma	☐	☐	Mitral Valve Prolapse	☐	☐	Thyroid Problems
☐	☐	Blood Disease	☐	☐	Headaches	☐	☐	Nervous Problems	☐	☐	Tobacco Habit
☐	☐	Cancer	☐	☐	Heart Murmur	☐	☐	Pacemaker	☐	☐	Tonsillitis
☐	☐	Chemical Dependency	☐	☐	Heart Problems	☐	☐	Psychiatric Care	☐	☐	Tuberculosis
☐	☐	Chemotherapy			Describe _____	☐	☐	Radiation Treatment	☐	☐	Ulcer
☐	☐	Circulatory Problems	☐	☐	Hemophilia	☐	☐	Respiratory Disease	☐	☐	Venereal Disease

MEDICATIONS

List medications you are currently taking:

_____

_____

ALLERGIES

_____

_____

Authorization

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I acknowledge HIPAA and grant permission to Dr. Anna Witanto and staff to release any necessary records to specialist, insurance, or anyone who will assist with the dental treatment. I acknowledge that I have received a copy of the Dental Materials Fact Sheet. I understand that I am financially responsible for all charges whether or not paid by insurance. I am aware that an unpaid balance over 90 days, will be charged a 1% finance charge. The above information is accurate and complete to the best of my knowledge. I will not hold Dr. Witanto or staff responsible for any errors or omissions I may have made in the completion of this form.

Signature _____ Date _____

Insured Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

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