Welcome

We are pleased to welcome you to Dr. Dodds Dental office. 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 your in maintaining your health.

Patient Information

Name ______________________________ Soc. Sec. # ______________
Last Name First Name Initial

Address ______________ City ______________ State ________ Zip ________

Home Phone ______________ Cell Phone ______________ Email ______________

Sex ☐ M ☐ F Age _____ Birthdate ______________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by ______________ Occupation ______________ Business Phone ______________

Business Address ______________ Business Email ______________

Whom may we thank for referring you? ______________

Notify in case of emergency ______________ Home Phone ______________

Cell Phone ______________ Business Phone ______________ Email ______________

Primary Insurance

Person Responsible for Account ______________ Soc. Sec. # ______________
Last Name First Name Initial

Birthdate ______________ Relationship to Patient ______________

Address (if different from patient) ______________ City ______________ State ________ Zip ________

Home Phone ______________ Cell Phone ______________ Email ______________

Person Responsible Employed by ______________ Occupation ______________ Business Phone ______________

Business Address ______________ Business Email ______________

Insurance Company ______________ Contract # ______________ Group # ______________ Subscriber # ______________

Insurance Phone ______________ Insurance Email ______________

Name of other dependents under this plan ______________

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name ______________ Soc. Sec. # ______________
Last Name First Name Initial

Birthdate ______________ Relationship to Patient ______________

Address (if different from patient) ______________ City ______________ State ________ Zip ________

Home Phone ______________ Cell Phone ______________ Email ______________

Subscriber Employed by ______________ Business Phone ______________ Business Email ______________

Insurance Company ______________ Contract # ______________ Group # ______________ Subscriber # ______________

Insurance Phone ______________ Insurance Email ______________

Name of other dependents under this plan ______________

Dental History

What would you like us to do today? ____________ Are you in dental discomfort today? ____________

Former Dentist ____________ Address ____________

Dentist's Email ____________ Phone ____________

Date of last dental care ____________ Date of last x-rays ____________

Check yes (Y) or no (N) if you have had problems with any of the following:

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

How often do you brush? ____________ How often do you floss? ____________

How do you feel about the appearance of your teeth? ____________

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Y☐ N☐

Other information about your dental health or previous treatment ____________

Medical History

Physician's name ____________ Phone ____________

Address ____________ Email ____________

Date of last visit ____________ Have you ever had any serious illnesses or operations? Y☐ N☐ If yes, describe ____________

Are you currently under physician care? Y☐ N☐ If yes, describe ____________

Have you ever had a blood transfusion? Y☐ N☐ If yes, give approximate dates ____________
Have you ever taken Fen-Phen/Redux? Y☐ N☐
Women: Are you pregnant? Y☐ N☐ Nursing? Y☐ N☐ Taking birth control pills? Y☐ N☐
Check (✓) yes or no whether you have had any of the following:

Y☐ N☐ AIDS/HIV Positive
Y☐ N☐ Alcohol/Drug Abuse
Y☐ N☐ Anaphylaxis
Y☐ N☐ Anemia
Y☐ N☐ Arthritis, Rheumatism
Y☐ N☐ Artificial heart valves
Y☐ N☐ Artificial joint
Y☐ N☐ Asthma
Y☐ N☐ Atopic (allergy prone)
Y☐ N☐ Back problems
Y☐ N☐ Blood disease
Y☐ N☐ Cancer
Y☐ N☐ Chemical dependency
Y☐ N☐ Cholesterol dependency
Y☐ N☐ Chemotherapy
Y☐ N☐ Circulatory problems
Y☐ N☐ Cortisone treatments
Y☐ N☐ Cough, persistent
Y☐ N☐ Cough up blood
Y☐ N☐ Diabetes
Y☐ N☐ Epilepsy
Y☐ N☐ Fainting
Y☐ N☐ Food allergies
Y☐ N☐ Glaucoma
Y☐ N☐ Headaches
Y☐ N☐ Heart murmur
Y☐ N☐ Heart problems
Describe ____________
Y☐ N☐ Hemophilia/
Abnormal bleeding
Y☐ N☐ Hereditary problems
Y☐ N☐ Herpes
Y☐ N☐ Hepatitis
Y☐ N☐ High blood pressure
Y☐ N☐ Jaw pain
Y☐ N☐ Kidney disease
or malfunction
Y☐ N☐ Liver disease
Y☐ N☐ Material allergies (latex,
wool, metal, chemicals)
Y☐ N☐ Mitral valve prolapse
Y☐ N☐ Nervous problems
Y☐ N☐ Pacemaker/Heart surgery
Y☐ N☐ Rapid weight gain or loss
Y☐ N☐ Radiation treatment
Y☐ N☐ Respiratory disease
Y☐ N☐ Rheumatic/Scarlet fever
Y☐ N☐ Seizures
Y☐ N☐ Shingles
Y☐ N☐ Shortness of breath
Y☐ N☐ Skin rash
Y☐ N☐ Spina Bifida
Y☐ N☐ Stroke
Y☐ N☐ Surgical implant
Y☐ N☐ Swelling of feet or ankles
Y☐ N☐ Thyroid disease
or malfunction
Y☐ N☐ Tobacco habit
Y☐ N☐ Tonsillitis
Y☐ N☐ Tuberculosis
Y☐ N☐ Ulcer/Colitis
Y☐ N☐ Venereal disease

Is patient currently taking any medications? If yes, list all:

____

____

Does patient have drug allergies? If yes, list all"

____

____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this formation will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ____________ Date ____________

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