Welcome!

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

Patient Information:

Date:_______________

Name ________________________________SS#/Insurance ID ________________

Home Phone(___)____________ Cell Phone (___)___________________________

Address ________________________________E-Mail________________________

City __________________________________ State _____ Zip _____________________________

Sex ___M ___F Age _____ Birthdate ________________ ___Married ___Divorced ___Single

Employer/School ____________________________ Occupation ________________________________

Employer/School Address ________________________________ Employer/School Phone (___)_________

Whom may we thank for referring you? ____

In case of emergency, who should be notified? __________________________ Phone (___)______________

Primary Insurance:

Person Responsible for Account ____

Relation to Patient __________________ Birthdate ___________________ Soc.Sec.# __________________

Address (If different from patient's) ____________________________________ Phone (___)______________

City_____________________________________ State ________ Zip _____________________________

Person Responsible Employed by _____________________________ Occupation ______________________

Business Address _____________________________ Business Phone (___)___________________________

Insurance Company ____

Group # ______________________________ Subscriber ID or Soc. Sec. #____________________________

Names of other dependants covered under this plan ____

Additional Insurance:

Is patient covered by additional insurance? ___Yes ___No

Subscriber Name ___________________ Birthdate _______________ Relation to Patient ___________________

Subscriber Employed by _________________________________ Business Phone (___)_____________________

Insurance Company ________________________________ Subscriber ID or Soc. Sec. #____________________

Group# ________________ Other Dependants covered by this plan ____________________________________

Dental History

Reason for Today's Visit________________________________Date of Last Dental Care____________________
Former Dentist_______________________________________Date of Last Dental X-Rays_________________

Check if you have had problems with any of the following:

__Bad Breath __Grinding Teeth __Sores or growths in the mouth
__Bleeding Gums __Loose teeth or broken fillings __Periodontal Treatment
__Clicking or popping jaw __Food collection between teeth __Sensitivity to cold/hot/sweets

How often do you floss?______________________How often do you brush?______________________________
Do you have any missing teeth?______________Are you interested in permanent replacement?___________
Are you unhappy with the appearance of your teeth?____
Is there anything you would like to change about your smile?____

Medical History

Physicians Name______________________________Date of last visit_________________________________
Have you ever taken any of the group of drugs collectively known as "fen-phen?" (Ionimin, Adipex, Fastin, Podimin, and Redux? __Yes __No
Have you had any serious illnesses or operations? __Yes __No If yes, please describe____________________
Have you ever had a blood transfusion? __Yes __No If yes, give approximate dates______________
(Women) Are you pregnant or nursing? __Yes __No Taking birth control pills? __Yes __No

Check if you have had any of the following:

__Anemia
__Arthritis/Rheumatism
__Artificial Heart Valves
__Artificial Joints
__Asthma
__Back Problems
__Blood Disease
__Cancer
__Chemical Dependency
__Chemotherapy
__Circulatory Problems
__Cortisone Treatments
__Cough, Persistant
__Cough up blood
__Diabetes
__Epilepsy
__Fainting
__Glaucoma
__Headaches
__Heart Murmur
__Heart Attack/Angina
__Hemophilia
__Hepatitis
__High Blood Pressure
__HIV/AIDS
__Jaw Pain
__Kidney Disease
__Liver Disease
__Mitral Valve Prolapse
__Pacemaker
__Radiation Treatment
__Respiratory Disease
__Rheumatic Fever
__Veneral Disease
__Scarlet Fever
__Short breath
__Skin Rash
__Stroke
__Swelling of joints
__Thyroid Problems
__Tobacco Habit
__Tonsillitis
__Tuberculosis
__Ulcer

Please list any medications you are currently taking:____

Are you allergic to any of the following:
__Penicillin __Latex __Aspirin __Epinephrine __Iodine __Sulfa __Metals (please list)_____________________
Have you ever had an adverse reaction to local anesthetic? __Yes __No If yes, please describe____________

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with ________________and assign directly to Dr. Winnicki all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
I understand that payment is due at the time of service. If working with insurance, I understand that my ESTIMATED portion is due at the time of service.
There will be a $75 per hour charge for all cancellations or missed appointments without giving The Dental Shoppe 48 hours notice.

____ ____________________________
Signature of patient, parent, guardian, or personal representative Date

____ ____________________________
Please print name Relationship to patient

____ ______________________

Dr. Signature **Date**

Blood Pressure ___________________________ **Pulse** __________________________________

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