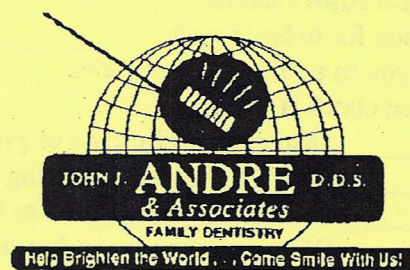


# Welcome to Our Practice



Patient's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_  
Guardian (if patient is a minor): \_\_\_\_\_  
Birthdates: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_ Home Phone (Area Code) : (\_\_\_\_) \_\_\_\_\_  
Work Phone (Area Code) : (\_\_\_\_) \_\_\_\_\_ Mobile Phone (Area Code) : (\_\_\_\_) \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Employer: \_\_\_\_\_  
How Long: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Status: \_\_\_\_\_ Minor: \_\_\_\_\_ Single: \_\_\_\_\_ Married: \_\_\_\_\_ Divorced: \_\_\_\_\_ Separated: \_\_\_\_\_ Widowed  
Spouse's Name: \_\_\_\_\_ Do you have children? Yes/No How Many? \_\_\_\_\_  
Names: \_\_\_\_\_  
Person Financially responsible for account: \_\_\_\_\_  
Relation to Patient: \_\_\_\_\_  
Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone Numbers Home: \_\_\_\_\_ Work: \_\_\_\_\_  
Contact in case of an Emergency: \_\_\_\_\_

## Dental Insurance: Please Present Card to Receptionist

Primary Dental Insurance Company: \_\_\_\_\_  
Policyholder: \_\_\_\_\_ ID#: \_\_\_\_\_  
Policyholder's Place of Employment: \_\_\_\_\_  
Policyholder's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_  
Secondary Dental Insurance Company: \_\_\_\_\_  
Policyholder: \_\_\_\_\_ ID#: \_\_\_\_\_

## ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with the above insurance carrier and assign directly to Dr. John J. Andre & Associates 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

How did you hear about our office? Yellow Pages: \_\_\_\_\_ Insurance: \_\_\_\_\_ Location: \_\_\_\_\_

Referred By: \_\_\_\_\_

Please fill out reverse side

**Dental Information**

Reason for today's visit: \_\_\_\_\_ Exam \_\_\_\_\_ Emergency \_\_\_\_\_ Consultation \_\_\_\_\_

Are you in pain? \_\_\_\_\_ Yes \_\_\_\_\_ No How Long? \_\_\_\_\_

Please check if you have:

- |  |                            |
|--|----------------------------|
| _____ Discomfort, clicking or popping in jaw | _____ Lost/Broken Fillings |
| _____ Red, Swollen or Bleeding Gums          | _____ Teeth Grinding       |
| _____ Sensitive Tooth, Teeth or Gums         | _____ Stained Teeth        |
| _____ Blisters/ Sores in or Around Mouth     | _____ Locking in Jaw       |
| _____ Broken/ Chipped Tooth                  | _____ Bad Breath           |
| _____ Snoring / Sleep Apnea                  |                            |

Are you happy with your smile? \_\_\_\_\_ Yes \_\_\_\_\_ No

Would you like a brighter smile? \_\_\_\_\_ Yes \_\_\_\_\_ No

Would you like to change anything? \_\_\_\_\_ Yes \_\_\_\_\_ No

If answered yes what would you like to change: \_\_\_\_\_

**Do You Require Pre-medication?** \_\_\_\_\_

Previous Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Last Dental Exam: \_\_\_\_\_ Last Dental X-ray: \_\_\_\_\_

Times a Day You Brush? \_\_\_\_\_ Times a Week You Floss? \_\_\_\_\_

**Medical History**

Circle any of the following, which you have had or now have:

- |                        |                          |                         |
|------------------------|--------------------------|-------------------------|
| Aids/HIV               | Congenital Heart Lesions | High/Low Blood Pressure |
| Anemia                 | Diabetes                 | Jaundice                |
| Arthritis              | Drug Addiction           | Kidney Treatment        |
| Artificial Joints      | Epilepsy                 | Pain in Jaw Joints      |
| Artificial Heart Valve | Fever Blisters           | Psychiatric Treatment   |
| Asthma                 | Heart Murmur             | Sinus Trouble           |
| Cancer                 | Hemophilia               | Stroke/ Heart Attack    |
| Cardiac Pacemaker      | Herpes                   | Tuberculosis (TB)       |
| Chemotherapy           | Hepatitis                | Venereal Disease        |

Other: \_\_\_\_\_

**List of Current Medications:** \_\_\_\_\_

Are You Allergic to any of the Following?	_____ Penicillin/Amox	_____ Codeine	_____ Latex
_____ Tetracycline	_____ Erythromycin	_____ Sulfa	_____ Other

<b>For Women Only:</b> Are You Pregnant? _____	If Yes, What Month? _____
Are You Nursing? _____	

- Our policy requires payment in full for all services rendered at the time of visit unless other arrangements have been made with the office manager. If the account is not paid within 90 days of the date of service and no financial arrangements have been made you will be responsible for legal fees, collection agency fees, interest charges and other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform of any changes to the information I have provided.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_