Welcome

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

Patient Information

Today's Date: _____/_____/_____ whom may we thank for referring you? _____

Name: _____ Sex: M F Birth date ___/____/___ Age_____ Home Phone (____) _____
Last Name First Name Middle Init

Address: _____ City: _____State:_____Zip: _____

Patients SS #: _____ E-Mail: _____ Cell Phone (_____) _____

Mothers Name: _____ Mother's SS #: _____ E-Mail: _____
(If patient is child)

Father Name: _____ Father's SS #: _____ E-Mail: _____
(If patient is child)

Patient Employer/School _____ Occupation _____

Employer/School Address _____Employer/School Phone (_____) _____

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

Primary Insurance

Primary Insured Name: _____ Date of Birth____/_____/_____
Last Name First Name Middle Initial

Relation to Patient: _____ Social Security # _____ ID #_____

Address: _____City: _____ State: _____ Zip: _____
(If different from patients)

Employer: _____ Group # _____Occupation _____

Business Address: _____ Work Phone (____) _____

Insurance Co Name: _____ Phone # (_____) _____

Ins Co. Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance

Primary Insured Name: _____ Date of Birth____/_____/_____
Last Name First Name Middle Initial

Relation to Patient: _____ Social Security # _____ ID #_____

Address: _____City: _____ State: _____ Zip: _____
(If different from patients)

Employer: _____ Group # _____Occupation: _____

Business Address: _____ Work Phone (____) _____

Insurance Co Name: _____ Phone # (_____) _____

Ins Co. Address: _____ City: _____ State: _____ Zip: _____

(PLEASE COMPLETE BOTH SIDES)

Dental History

Reason for today's visit _____ Date of last dental care _____/_____/_____

Former Dentist _____ Date of last dental X-rays _____/_____/_____

Former Dentist Address _____ Phone # (____)_____

Please answer **yes** or **no** if you have had problems with any of the following:

☐ 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 _____ Phone # (____)_____ Date of last visit _____/_____/_____

Please answer yes or no to the following:

Have you ever taken any drug referred to as "fen-phen?" Yes / No (*These include combinations of **Ionimin**, **Adipex**, **Fastin**, **Pondimin** and **Redux***).

Have you ever had any serious Illness or operation? 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 Due Date _____/_____/_____ Nursing? Yes / No Taking birth control pills? Yes / No

Answer check if you have had any of the following:

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

LIST ALL CURRENT MEDICATIONS:

ALLERGIES:

Authorization

I certify that I, and/or my dependents(s) have insurance coverage with _____and assign directly to *Dr.Lance K. Skinkys*

*Na*me of insurance company (ies)

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. The above named dentist may use my health care information to the above named insurance companies for the purpose of obtaining payment and determining insurance benefits.

X_____ _____/_____/_____

Signature of Patient, Parent, Guardian or Personal Representative — Date

X_____ _____

Print Name of Patient, Parent, Guardian or Personal Representative — Relationship to patient