ROBERT DAWE, DDS *WELCOME!*

1. About You:

Today's Date: _____/_____/_____
Patient Name (Last, First, M.I.): _____
What you prefer to be called: _____ Male Female (circle one)
Birth date: _____/_____/_____ Age: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Home Phone #: _____
Work Phone #: _____ Ext: _____
Cell Phone #s: _____
E-mail Address: _____
Referred By: _____
Occupation: _____
Employer: _____ How Long? _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Status (circle one): Minor Single Married Divorced Separated Widowed
Spouse's Name: _____

2. Insurance Info

Primary Dental Insurance
Co. Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____
Insured's SS #: _____
Group # (Plan, Local, or Policy #): _____
Insured's Name: _____
Relation: _____ Date of Birth: _____/_____/_____
Insured's Employer: _____

Secondary Dental Insurance
Co. Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____
Insured's SS #: _____
Group # (Plan, Local, or Policy #): _____
Insured's Name: _____
Relation: _____ Date of Birth: _____/_____/_____
Insured's Employer: _____

3. Account Info

Person ultimately responsible for account

Name: _____
Relation: _____
Billing Address: _____
City: _____ State: _____ Zip: _____
Work Phone #: _____
Payment method (circle one): cash check credit card
Card #: _____ Exp date_____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid for by my insurance company.
Signature:_____

4. In Event of Emergency

Who should we contact? _____
Relation: _____
Home Phone #: _____
Work/Cell Phone #: _____
Who is your Medical Doctor? _____
M.D.'s Phone #: _____

5. Dental Info

Reason for today's visit (circle one): Exam Emergency Consultation
Are you in pain? No Yes How Long? _____
Please indicate by circling any of the following problems:

Discomfort, clicking or popping in jaw	Lost/Broken Filling(s)	Stained teeth
Red, swollen or bleeding gums	Teeth Grinding	Locking Jaw
Sensitive tooth, teeth or gums	Ringing in Ears	Bad breath
Blisters/Sores in or around the mouth	Broken/Chipped tooth	

Other _____

Previous Dentist Name and Phone #: _____ (____)_____
Last Dental Exam: _____/_____/_____ Last Dental X-rays: _____/_____/_____

Times a day you brush? _____ Times a week you floss? _____
What type of tooth brush bristles do you use? Soft Medium Hard

6. Medical History

Are you taking any of the following medications? Nerve pills Muscle Relaxers Pain killers (including aspirin) Stimulants Blood Thinners Tranquilizers Insulin

List all medications taken (prescription and others)

_____
_____
_____
_____

Do you require antibiotic pre-medication as directed by your physician due to a medical condition? Yes No

Do you frequently get cold sores or canker sores? Yes No

Do you have or ever had any of the following diseases or medical conditions?

Y N Heart Attack / Stroke	**Y N** Kidney Problems	**Y N** Cancer/Tumors
Y N Heart Surg./Pacemaker	**Y N** Liver Problems	**Y N** Shingles
Y N Heart Murmur	**Y N** Respiratory Problems	**Y N** Hepatitis
Y N Rheumatic Fever	**Y N** Sinus Problems	**Y N** HIV+/AIDS/ARC
Y N Mitral Valve Prolapse	**Y N** Stomach Problems/Ulcers	**Y N** Arthritis/Rheumatism
Y N Artificial Valves	**Y N** Psychiatric Problems	**Y N** Artificial bones/joints
Y N Heart Disease	**Y N** Venereal Disease	date of placement:_____
Y N Congenital Heart Defect	**Y N** Alcohol/Drug Abuse	**Y N** Fainting/Seizures/Epilepsy
Y N Chest Pains	**Y N** Tuberculosis TB	**Y N** Severe/Frequent Headaches
Y N Scarlet Fever	**Y N** Jaw Problems TMJ/TMD	**Y N** Frequent Neck Pain
Y N Chemotherapy	**Y N** Asthma	**Y N** Alzheimer's Disease
Y N Diabetes/Hypoglycemia	**Y N** Leukemia	**Y N** Anemia
Y N High/Low Blood Pressure	**Y N** Bleeding Problems	**Y N** Glaucoma
Y N Back Problems	**Y N** Emphysema	

Please list any other medical conditions you have or ever had: _____
_____.

Are you allergic to any of the following? Latex Penicillin/Amoxicillin Tetracycline Aspirin Dental Anesthetics **Others**_____

Do you use tobacco? No Yes How used?_____ How much?_____ How long?_____

Are you pregnant? No Yes

We invited you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If 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, collections agency fees, interest charges and any 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 this office of any changes to the information I have provided.

Signature_____ Date_____/_____/_____
(circle one) Adult Patient Parent or Guardian