WELCOME TO GENESIS FAMILY DENTAL

Please take a few minutes to answer the following questions
so we can better assist you with your dental needs

PATIENT INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____

Address _____ City _____ State _____

Zip _____ Home Phone _____ Cell Phone _____

Email address _____

Sex ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Whom may we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

PRIMARY DENTAL INSURANCE

Person responsible for account _____

Relationship to Patient _____ Birthdate _____ Soc. Sec.# _____

Address _____ City _____ State _____

Zip _____ Home Phone _____ Cell Phone _____

Responsible Party Employer _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D.# _____ Group# _____ Plan# _____

ADDITIONAL INSURANCE

Insured name _____

Relationship to Patient _____ Birthdate _____ Soc. Sec.# _____

Address _____ City _____ State _____

Zip _____ Home Phone _____ Cell Phone _____

Insured Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D.# _____ Group# _____ Plan# _____

DENTAL HISTORY

Former Dentist _____ Date of last x-rays _____

City and State _____ How often do you floss? _____

Date of last dental visit _____ How often do you brush? _____

PLEASE CHECK ALL THAT APPLY

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Blisters on lips or mouth
- ☐ Finger nail biting
- ☐ Grinding teeth
- ☐ Lip or cheek biting
- ☐ Loose teeth or broken filings
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal Treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Frequent headaches
- ☐ Jaw, head or neck injuries
- ☐ Jaw difficulty: clicking and/or pain
- ☐ Tooth pain

MEDICAL HISTORY

Physician's name _____ Date of last visit _____

	YES	NO
Are you currently under medical treatment?	☐	☐
Have you ever had any serious illnesses or operations?	☐	☐
Are you currently taking any medication?	☐	☐

Please describe: _____

_____

Do you smoke?	☐	☐
Do you use alcohol, cocaine or other drugs?	☐	☐
Do you wear contacts?	☐	☐

Have you had any reactions to the following:

	YES	NO
Local anesthetics (eg. novocaine)	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Baribituates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐
(Women only) Are you:		
Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills	☐	☐

PLEASE CHECK ALL THAT APPLY

- ☐ Aids
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding abnormally with extractions or surgery
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough-persistant or bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting or Dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis Type_____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet/Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or growth on head/ neck
- ☐ Ulcer
- ☐ Venereal Disease

ASSIGNMENT AND RELEASE

I hearby authorize payment to Dr._____ for all insurance benefits otherwise payable to me for services rendered.I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above Doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____