

WELCOME



Patient #	Appointment Date & Time		
Name	Nickname	Sex	
Birthdate	Age	SS#	
Address			
City	State	Zip	Home Phone
Dentist	Physician		
How did you hear about our office?			
What questions would you like answered today by Dr. Pritchard?			

COMPLETE FOR A CHILD PATIENT:

School	Grade	Musical Instrument	
Siblings	Hobbies/Interests/Sports		
Father's Name	Home Phone	Work Phone	
Address	City	State	Zip
Father's SS#	Employer		
Mother's Name	Home Phone	Work Phone	
Address	City	State	Zip
Mother's SS#	Employer		

COMPLETE FOR AN ADULT PATIENT:

Your Employer	Work Phone	
Spouse's Name	Employer	Work Phone
Spouse's SS#		

DENTAL INSURANCE INFORMATION: Please use information from your insurance card to complete this section.

Primary		Secondary	
Ins. Co.		Ins. Co.	
Address		Address	
City/St./Zip		City/St./Zip	
Phone#		Phone#	
Insured		Insured	
SS#	DOB	SS#	DOB
Group#		Group#	
Employer		Employer	
Person(s) responsible for payment & relationship to patient:			

PATIENT HISTORY:

Patient's Height

Weight

Father's Height

Mother's Height

In your own words, what is the problem?

Does anyone else in the family have a similar problem? if so, who?

Names of other family members previously examined in this office:

Date of last cleaning?

Have you ever had any serious problems associated with previous dental treatment?

If so, please explain:

HEALTH HISTORY:

Has the patient had any of the following:

- Baby teeth removed by dentist Yes No • Diabetes Yes No
- Major fall or accident involving head, face or teeth Yes No • Hepatitis Yes No
- Discomfort with bite Yes No • Anemia Yes No
- Habits such as nail biting, thumbsucking, lip biting Yes No • Tuberculosis or lung disease Yes No
- Speech problems Yes No • Artificial joint Yes No
- Difficulty opening mouth Yes No • Abnormal blood pressure Yes No
- Noises or discomfort in/or around jaw joint Yes No • Epilepsy, seizures, convulsions Yes No
- Jaw locking or getting stuck Yes No • Rheumatic fever, heart murmur or other heart problems Yes No
- Clenches jaw muscles Yes No
- Grinds teeth Yes No • Heart surgery, heart pacemaker, mitral valve prolapse Yes No
- Frequent headaches Yes No
- Sinus trouble Yes No • Venereal Disease Yes No
- Difficulty breathing through the nose (awake and/or asleep) Yes No • HIV positive/AIDS Yes No
- Cold sores Yes No • Hospitalized overnight Yes No
- Drug allergies/Penicillin, Latex, other Yes No • Taking any medications Yes No
- Hay fever, asthma or other allergies Yes No • If so, what? _____
- If female, are you pregnant? Yes No

Please add anything you feel is important: _____

Signature/Date _____ Date Reviewed/Initials _____

Acknowledgement of Receipt of Notice of Privacy Practices

**** You may refuse to sign this Acknowledgment ****

I, _____, have recieved a copy of this office's Notice of Privacy Practices.

(Please print name)

(Signature)

(Date)

We atttempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but could not because the Individual refused to sign.

Date: _____

Comments: _____