Welcome!

We are pleased to welcome you to our practice. Please take a few minutes to fill out these forms as completely as you can. If you have any questions, we'll be glad to help you. We look forward to helping you maintain your dental health.

Patient Information Home Phone: _____Today's Date: _____ /_____ /_____

Name: _____ Soc. Sec. #_____
Last First Initial

Address: _____

City: _____ State: _____ Zip: _____

Sex: M F Age: _____ Birthdate: _____ /_____ /_____ __Single __Married __Widow __Separated __Divorced

Patient Employed By: _____ Occupation: _____

Business Phone: _____ Cell Phone: _____ Email: _____

How did you find out about our office? _____

In case of emergency, who should be notified? (Name & Number) _____

_____

Person Responsible for the Account: _____
Last First Middle Initial

Address (if different than patient): _____

City: _____ State: _____ Zip: _____

Primary Dental Insurance: Company Name: _____ Phone: _____

Subscriber ID#:_____ Group #:_____

Please let us know if you are covered by a secondary insurance company.

Medical History

Primary Care Doctor: _____ Date of last Doctor visit: _____
Have you had any serious illness or operations? ___Yes ___No If yes, give approximate date: _____
_____
_____
Have you ever had a blood transfusion? ___Yes ___No If Yes, give approximate date: _____
(Women) Are you pregnant? ___Yes ___No Nursing? ___Yes ___No Taking birth control pills? ___Yes ___No
Have you ever had BOTOX injections? ___Yes ___No

Check if you have or have had any of the following:

__AIDS	__Cortisone Treatment	__Hepatitis	__Rheumatic Fever
__Anemia	__Cough, persistent	__High Blood Pressure	__Scarlet Fever
__Arthritis, Rheumatism	__Cough up blood	__HIV positive	__Shortness of breath
__Artificial Heart Valve	__Diabetes	__Jaw Pain	__Skin Rash
__Asthma	__Epilepsy	__Kidney Disease	__Stroke
__Back Problems	__Fainting	__Liver Disease	__Swelling of feet/ankles
__Blood Disease	__Glaucoma	__Mitral Valve Prolapse	__Thyroid Problems
__Cancer	__Headaches	__Nervous Problems	__Tobacco Habit
__Chemical Dependency	__Heart Murmur	__Pacemaker	__Tonsillitis
__Chemotherapy	__Heart Problems	__Psychiatric Care	__Tuberculosis
__Circulatory Problems (describe) _____		__Radiation Treatment	__Ulcer
__Hemophilia	__Respiratory Disease	__Venereal Disease	

Please list any medications you are currently taking:

Medicine:	**Dose:**	**Allergies to medication:**	**Reaction:**
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	

Authorization:

I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that payment (or estimated insurance co-payment) is due in full at time of treatment unless prior arrangements have been approved by Dr. Garrison in writing. I further understand that I am fully financially responsible for any and all collection fees charged to Dr. Garrison should my account become past due and collection activities proceed.

I authorize Dr. Garrison to take photographs for his use in seminars, patient education, laboratory communication, marketing, and post-graduation education requirements.

If patient is a minor (under age 18), I agree that I am acting as minor's parent or legal guardian. I authorize Dr. Garrison or his staff to perform dental care for above mentioned minor using their professional judgment in my absence. I further understand that ultimately I am responsible for above minor's account, whether insurance contracts or divorce rulings state otherwise.

Signature: _____ **Date:** _____

What would you like us to do for you?

- Help me keep my teeth for the rest of my life
- Help me improve my smile
- Examine my mouth and give me a report
- I want to prevent decay and toothaches
- I want fresher breath
- I want whiter teeth
- Stop my gums from bleeding
- Get me out of pain
- Fix the hole in my tooth
- Give me more teeth to chew with
- Remove my wisdom teeth
- Teach me how to care for my teeth

Comments: _____

_____

All of the requests above are possible to achieve. They will require some work on our part and yours as well. We will try to create a plan for you that will meet the goals you have for your mouth. It may take some time, but when we are finished, you will have the satisfaction of knowing it was done right and that you know how to care for your mouth and protect your investment in good dental health.

Sincerely,
Dr. Matt Garrison and Staff

Dental History

Former dentist: _____ Address: _____

Reason for leaving former dentist: _____

Date of last dental visit: _____ Date of last dental x-rays: _____

Check if you've 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 mouth

How often do you floss? _____ How often do you brush? _____