



SALLY C. POWELL | DDS
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WELCOME | We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. 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's Name: _____ SSN: _____
First Middle Last

Date of Birth: _____ Age: _____ Sex: M F Married Single Widowed Separated Divorced

Home Address: _____

City State Zip Code

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Whom may we thank for referring you? _____

Notify in case of emergency: _____

Home Phone: _____ Cell Phone: _____ Business Phone: _____

Person responsible for account

Name: _____ SSN: _____
First Middle Last

Date of Birth: _____ Relationship to the patient: _____

Home Address (if different from patient): _____

City State Zip Code

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Insurance Information

Subscriber Name: _____ Employer: _____
First Middle Last

Date of Birth: _____ SSN: _____

Insurance Company: _____ Phone: _____

Contract #: _____ Group #: _____ Subscriber #: _____

Name of other dependents under the plan: _____

Dental History

Describe your dental concerns: _____

Former dentist: _____ Phone: _____ Date of last dental care: _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? YES NO

If yes, please explain: _____

Medical History

Primary Care Physician: _____ Phone: _____

Preferred Pharmacy: _____

Please check all that apply:

- | | | | | |
|---|--|---|---|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rapid Weight Loss |
| <input type="checkbox"/> Alpha-gal | <input type="checkbox"/> Autism | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Blood Thinner | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Mitral Valve | <input type="checkbox"/> Thyroid Disease |
| | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Ulcer/Colitis |
| | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Herpes | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Venereal Disease |

Tobacco Use YES NO Vape/E-Cigs/Pouches YES NO Marijuana YES NO (if yes, what form/frequency?) _____

Alcohol Use (3 drinks or more a day) YES NO FEMALE: Pregnant or Planning Pregnancy YES NO Nursing YES NO

If any conditions not listed above or need further clarification, please describe: _____

List any surgeries in the last 5 years: _____

Do you take antibiotic premedication for your dental visits? YES NO (if yes, please list medication that is taken): _____

Are you taking any medications or vitamins (prescription and non-prescription)? YES NO (if yes, please list medication that is taken): _____

Have you taken or are you taking any Bisphosphate drugs used to treat osteoporosis or Paget's disease?
(ex: Fosamax, Actonel, Bonvia, Reclast, Didronel, Zometa, etc.) YES NO (if yes, please list the drug and date taken): _____

Does the patient have any allergies? (ie: drug, environmental, food) YES NO (if yes, please list all): _____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to 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.

Signature _____ Date _____

FOR MINORS UNDER THE AGE OF 18:

Parent /Guardian Name _____ Relationship to patient _____

Signature _____ Date _____

Payment is due in full at time of treatment.