Donald R. Welsh, Jr., D.M.D.
Samantha D. King, D.M.D.

PATIENT INFORMATION

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. Name _____ I prefer to be called _____ ❑ M ❑ F

❑ Single ❑ Married Birthdate _____ Social Security Number _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-Mail _____

Employer _____ Business Phone _____

Business Address _____ City _____ State _____ Zip _____

Whom may we thank for referring you to our office? _____

How do you prefer to be contacted? ❑ Home Phone ❑ Cell Phone ❑ Business Phone ❑ E-Mail

Are you interested in text notification for appointments? ❑ Yes ❑ No

DENTAL INSURANCE INFORMATION

Name of Insured Person _____ Relationship to Patient _____

Employer _____ Birthdate of Insured _____

Insurance Co. Name _____ Subscriber ID _____ Group # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

SECONDARY DENTAL INSURANCE INFORMATION

Name of Insured Person _____ Relationship to Patient _____

Employer _____ Birthdate of Insured _____

Insurance Co. Name _____ Subscriber ID _____ Group # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

RESPONSIBLE PARTY

If the person responsible for payment is someone other than the patient, please complete the section below so that we have the appropriate billing information for your account.

Name of Person Responsible for Payment _____ Relationship to Patient _____

Is the person responsible for payment currently a patient in our office? ❑ Yes ❑ No

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-Mail _____

Employer _____ Business Phone _____

Business Address _____ City _____ State _____ Zip _____

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HEALTH HISTORY

Patient Name _____ Birthdate _____

Physician's Name _____ Physician's Phone _____

Have you ever been advised to take prophylactic antibiotics before dental treatment? . . . . . ❑ Yes ❑ No

If yes, please list reason(s) _____

Have you ever been advised not to take a particular medication? . . . . . ❑ Yes ❑ No

If yes, please list _____

Do you take blood thinners? . . . . . ❑ Yes ❑ No

Have you ever taken bone loss prevention drugs (bisphosphonates) for osteoporosis, metastatic cancer, or other conditions? Examples of bisphosphonates are alendronate (Fosamax), risedronate (Actonel), pamidronate (Aredia), Ibandronate (Boniva), and zoledronate (Zometa, Reclast) . . . . . ❑ Yes ❑ No

Are you allergic to any of the following?

Yes	No	
❑	❑	Latex
❑	❑	Penicillin or any other antibiotic: If yes, please list _____
❑	❑	Other allergies: If yes, please list _____

Do you have, or have you ever had, any of the following?

Yes	No		Yes	No	
❑	❑	Alcohol or Drug Addiction	❑	❑	HIV or AIDS
❑	❑	Anaphylaxis	❑	❑	HPV (Human Papilloma Virus)
❑	❑	Artificial Joint Replacement (hip, knee, etc.)	❑	❑	Kidney Problems
❑	❑	Artificial Heart Valve	❑	❑	Liver Problems
❑	❑	Asthma	❑	❑	Lung Problems
❑	❑	Bleeding Problems or Bleeding Disorder	❑	❑	Major Operations
❑	❑	Cancer	❑	❑	Memory Problems
❑	❑	Chemotherapy	❑	❑	Osteoporosis / Osteopenia
❑	❑	Cold Sores	❑	❑	Psychiatric Care
❑	❑	Congenital Heart Failure	❑	❑	Respiratory Problems
❑	❑	Corticosteroid Treatment	❑	❑	Radiation Treatment
❑	❑	Dental Phobia or Anxiety	❑	❑	Rheumatic Fever
❑	❑	Diabetes	❑	❑	Sinus Problems
❑	❑	Endocarditis	❑	❑	Stomach or Intestinal Problems
❑	❑	Epilepsy or Seizures	❑	❑	Stroke
❑	❑	Fainting Spells or Dizziness	❑	❑	Thyroid Problems
❑	❑	Heart Pacemaker	❑	❑	Tuberculosis
❑	❑	Heart Attack or Heart Problems	❑	❑	Tumors or Growths
❑	❑	Hepatitis	❑	❑	If Female, Are you Pregnant?
❑	❑	History of Tobacco Use or Vaping	❑	❑	Other Health Problems
❑	❑	High Blood Pressure			

Please provide additional information for all "Yes" responses:

_____

_____

Do you take any medications? . . . . . ❑ Yes ❑ No

If Yes, please list medications and the reason why you are taking them:

Medication: _____ Reason: _____ Medication: _____ Reason: _____

Medication: _____ Reason: _____ Medication: _____ Reason: _____

Medication: _____ Reason: _____ Medication: _____ Reason: _____

Medication: _____ Reason: _____ Medication: _____ Reason: _____

Signature: _____ **Date:** _____

DONALD R. WELSH, JR., D.M.D.
SAMANTHA D. KING, D.M.D.

DENTAL HISTORY

Patient Name _____

What is the reason for your dental visit today? _____

Do you currently have any teeth that are sensitive?

❑ Yes ❑ No If Yes, please explain _____

Do you have a history of trauma to any teeth?

❑ Yes ❑ No If Yes, please explain _____

When was the last time you saw a dentist? _____

When was your last professional cleaning? _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Have you ever been treated for periodontal disease (gum disease)? . . . . . ❑ Yes ❑ No

Do you feel that you can chew well with your teeth? . . . . . ❑ Yes ❑ No

Do you grind or clench your teeth? . . . . . ❑ Yes ❑ No

Do you ever have jaw pain or jaw muscle soreness? . . . . . ❑ Yes ❑ No

Have you ever worn a night-guard or been told that you should? . . . . . ❑ Yes ❑ No

Do you have any teeth or restorations that you are unhappy with? . . . . . ❑ Yes ❑ No

Would you like to discuss esthetic improvements that can be made to your smile? . . . . . ❑ Yes ❑ No

DONALD R. WELSH, JR., D.M.D.
SAMANTHA D. KING, D.M.D.

HIPAA PRIVACY PRACTICES ACKNOWLEDGMENT

By signing below, I acknowledge that I have been provided a copy of the Donald R. Welsh, Jr. D.M.D. and Samantha King, D.M.D. Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the medical group listed at the beginning of this Notice, and how I may obtain access to and control of this information.

By signing below, I also consent to the use and disclosure of my health information to treat me and arrange for my dental care, to seek and receive payment for services given to me, and for the business operations of the dental practice, its staff, and its business associates.

E-MAIL CONSENT

For your convenience, we offer patients the opportunity to correspond directly with us via e-mail as long as you provide your consent recognizing that e-mail is not a secure form of communication. There is some risk that health information contained in such e-mail may be misdirected, disclosed to or intercepted by unauthorized third parties.

I consent and accept this risk of e-mail communication between the provider and myself. Further, I understand that my provider will use reasonable means to protect the security and confidentiality of said e-mails, but cannot be held liable for improper disclosure of information not caused by intentional misconduct.

Signature of Patient, or Patient's Representative _____

Print Name of Patient, or Patient's Representative _____

Date _____

Description of Personal Representative _____

Samantha King, DMD

320 Union Street
Portsmouth, NH 03801
(603) 436-2144

Appointment Cancellation Policy

We ask that you give our office 1 full business day (or more) if you are unable to keep your appointment. Missed appointments or appointments cancelled or re-scheduled with less than 1 full business day will be charged $75. This fee cannot be billed to your insurance company and will be your responsibility. No future appointments can be scheduled without the payment of this fee.

We appreciate your understanding and consideration.

I have read the above and by signing below I acknowledge this cancellation policy.

_____	_____	_____
Print Patient Name	Signature	Date