

Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental health care needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Date _____

Home # _____

Cell # _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Soc. Sec. # _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: Female Male Minor Single Married Divorced Widowed Separated

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

If Patient is a Student, Name of School / College _____ City _____ State _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Social Security # _____ Birthdate _____

Employer _____ Work Phone _____

Is this Person Currently a Patient in our Office? Yes No

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

DO YOU HAVE SECONDARY DENTAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Over Please

If you could change something about your smile, what would it be? _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

Previous Dentist _____ Office Phone _____ Date of Last Exam _____

	Yes	No		Yes	No
1. Are you under medical treatment now?	<input type="checkbox"/>	<input type="checkbox"/>	7. Are you allergic to or have you had any reactions to the following?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized for any surgical operation or serious illness?	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetics (e.g. novocaine)	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medication(s) including Fosomax (i.e. bisphosphonates) and any non prescription medications?	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what medication(s) are you taking? _____			Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>
			Latex	<input type="checkbox"/>	<input type="checkbox"/>
			Sedatives	<input type="checkbox"/>	<input type="checkbox"/>
			Codeine	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you use alcohol, cocaine or other drugs?	<input type="checkbox"/>	<input type="checkbox"/>	Metal/Acrylic	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever taken Phen-Fen or Redux?	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
			8. Women Only:		
9. Do you have or have you had any of the following?			a) Are you pregnant or think you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Yes No	Yes No	Yes No	b) Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> <input type="checkbox"/> Chest Pains	<input type="checkbox"/> <input type="checkbox"/> Frequent Headaches	c) Are you taking birth control pills	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> <input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> <input type="checkbox"/> Genital Herpes			
<input type="checkbox"/> <input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> <input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> <input type="checkbox"/> Scarlet Fever	
<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Convulsions	<input type="checkbox"/> <input type="checkbox"/> Hay Fever	<input type="checkbox"/> <input type="checkbox"/> Kidney Problems	<input type="checkbox"/> <input type="checkbox"/> Shingles	
<input type="checkbox"/> <input type="checkbox"/> Angina	<input type="checkbox"/> <input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> <input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> <input type="checkbox"/> Leukemia	<input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease	
<input type="checkbox"/> <input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Heart Murmur	<input type="checkbox"/> <input type="checkbox"/> Liver Disease	<input type="checkbox"/> <input type="checkbox"/> Sinus Trouble	
<input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> <input type="checkbox"/> Drug Addiction	<input type="checkbox"/> <input type="checkbox"/> Heart Pace Maker	<input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> <input type="checkbox"/> Artificial Joint	<input type="checkbox"/> <input type="checkbox"/> Easily Winded	<input type="checkbox"/> <input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> <input type="checkbox"/> Lung Disease	<input type="checkbox"/> <input type="checkbox"/> Stomach/Intestinal Disease	
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Emphysema	<input type="checkbox"/> <input type="checkbox"/> Hemophilia	<input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> <input type="checkbox"/> Stroke	
<input type="checkbox"/> <input type="checkbox"/> Blood Disease	<input type="checkbox"/> <input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> <input type="checkbox"/> Hepatitis A	<input type="checkbox"/> <input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> <input type="checkbox"/> Swelling of Limbs	
<input type="checkbox"/> <input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> <input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> <input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> <input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> <input type="checkbox"/> Thyroid Disease	
<input type="checkbox"/> <input type="checkbox"/> Breathing Problems	<input type="checkbox"/> <input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> <input type="checkbox"/> Herpes	<input type="checkbox"/> <input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> <input type="checkbox"/> Tonsillitis	
<input type="checkbox"/> <input type="checkbox"/> Bruise Easily	<input type="checkbox"/> <input type="checkbox"/> Fainting Spells / Dizziness	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Radiation Treatments	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Frequent Cough	<input type="checkbox"/> <input type="checkbox"/> Hives or Rash	<input type="checkbox"/> <input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> <input type="checkbox"/> Tumors or Growths	
<input type="checkbox"/> <input type="checkbox"/> Chemotherapy	<input type="checkbox"/> <input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> <input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> <input type="checkbox"/> Renal Dialysis	<input type="checkbox"/> <input type="checkbox"/> Ulcers	
			<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/> Venereal Disease	
			<input type="checkbox"/> <input type="checkbox"/> Rheumatism	<input type="checkbox"/> <input type="checkbox"/> Yellow Jaundice	

Patient Dental History

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>	8. Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel pain to any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had any difficult extractions in the past?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you had any orthodontic work?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you ever had any prolonged bleeding following extractions?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever experienced any of the following problems in your jaw?			14. Have you ever had instruction on the correct method of brushing your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
a) Clicking?	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever had instructions on the care of your gums?	<input type="checkbox"/>	<input type="checkbox"/>
a) Pain (joint, ear, side of face)?	<input type="checkbox"/>	<input type="checkbox"/>			
a) Difficulty in opening or closing?	<input type="checkbox"/>	<input type="checkbox"/>			
a) Difficulty in chewing?	<input type="checkbox"/>	<input type="checkbox"/>			

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for the services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I consent to any advisable and necessary dental treatment to be administered by the dentist or staff for diagnostic purposes or dental restoration.

X
Signature of patient or parent if minor _____

_____ Date