Date_____

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 healthcare 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.

Patient Information (CONFIDENTIAL)

Soc. Sec. # _____

Cell Phone _____

Name _____ **Birthdate** _____ **Home Phone** _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ City_____ State _____ Work Phone _____

If Student, Name of School/College _____ City _____ State _____ ☐Full Time ☐Part Time

Responsible Party

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

Address _____ Home Phone _____

Birthdate _____

Employer _____ Work Phone _____ SS# _____

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

Primary Insurance Coverage

Insurance Company _____ Group # _____ Policy/ID # _____

Name of Insured _____ to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

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

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Secondary Insurance Coverage

Insurance Company _____ Group # _____ Policy/ID # _____

Name of Insured _____ to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

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

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Whom May We Thank for Referring You?_____

Person to Contact in Case of Emergency _____ Phone_____

Over Please

Patient Medical History

Name of Primary Medical Doctor:_____ City:_____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes please explain _____		
3. **List ALL medicines, supplements**		
4. Do you take medicine for your bones?	☐	☐
5. Do you use any tobacco products?	☐	☐
6. Do you use recreational drugs?	☐	☐

8. **Are you allergic to or have you had any reactions to the following?**	Yes	No
Local Anesthetics (eg. Novocaine)	☐	☐
Penicillin	☐	☐
Sulfa Drugs	☐	☐
Other Antibiotics	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury etc.)	☐	☐
Latex Rubber	☐	☐
Other (place list)_____	☐	☐

9. Women Only:	Yes	No
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking, oral contraceptives?	☐	☐

7. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	**Heart Disease**	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	**Cardiac Pacemaker**	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	**Heart Murmur**	☐	☐	Stroke	☐	☐
Hereditary Angioedema	☐	☐	**Frequent headaches**	☐	☐	Tuberculosis	☐	☐
Fainting / Seizures	☐	☐	**Bleeding Disorders**	☐	☐	Radiation therapy	☐	☐
Asthma	☐	☐	**Anemia**	☐	☐	Glaucoma	☐	☐
Low Blood Pressure	☐	☐	**Emphysema**	☐	☐	Liver Disease	☐	☐
Epilepsy / Convulsions	☐	☐	**Cancer**	☐	☐	Respiratory Problems	☐	☐
Leukemia	☐	☐	**Arthritis**	☐	☐	Blood Transfusion	☐	☐
Diabetes	☐	☐	**Joint Replacement or Implant**	☐	☐	Organ Transplants	☐	☐
Kidney Diseases	☐	☐	**Hepatitis / Jaundice**	☐	☐	Other	☐	☐
AIDS or HIV Infection	☐	☐	**Drug or Alcohol Addiction**	☐	☐	Do you snore loudly?	☐	☐
Thyroid Problem	☐	☐	**Stomach Troubles / Ulcers**	☐	☐	Do you have sleep apnea?	☐	☐
Psychiatric Problems	☐	☐						
Chemotherapy	☐	☐						

Patient Dental History

Name of Previous Dentist and Location_____ Date of Last Exam:_____

	Yes	No
1. Do you gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your month?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking / Popping	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do your lips or throat ever swell?	☐	☐
9. Do you clench or grind our teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12 Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
if yes date of placement_____	☐	☐
15. **Do you like your smile?**	☐	☐

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 services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of patient (or parent if minor)

Doctor's Comments _____

_____

_____ **Signature** _____ **Date** _____