



Thank you for choosing our practice for your dental needs. We strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please complete this form in ink. If you have any questions or need assistance, we will be happy to help.

PATIENT INFORMATION (CONFIDENTIAL)

Name: Last _____ First _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Birthdate: ____ / ____ / ____ SSN#: ____ - ____ - ____ Sex: Female Male

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____ Email _____

I prefer to be contacted via: Home Cell Phone Work Email No Preference

Check Appropriate Box: Married Widowed Single Minor Separated Divorced Partnered for ____ years

Employer: _____ Occupation: _____

If Student, Name of School: _____ City: _____ State: _____ Full Time Part Time

Person to Contact in Case of Emergency: _____ Phone (____) _____

Whom May We Thank for Referring You to Us? _____

INSURANCE INFORMATION

Name of Insured: Last _____ First _____ Relationship to Patient: _____

Birthdate: ____ / ____ / ____ SSN# ____ - ____ - ____ Driver's License # _____

Employer: _____ Work Phone (____) _____ x

Employer's Address: _____ Union or Local # _____

Insurance Company: _____ Group # _____ Policy/ID # _____

DO YOU HAVE ADDITIONAL INSURANCE? Yes No **IF YES, COMPLETE THE FOLLOWING:**

Name of Insured: Last _____ First _____ Relationship to Patient: _____

Birthdate: ____ / ____ / ____ SSN# ____ - ____ - ____ Driver's License # _____

Employer: _____ Work Phone (____) _____ x

Employer's Address: _____ Union or Local # _____

Insurance Company: _____ Group # _____ Policy/ID # _____

RESPONSIBLE PARTY

Name of person responsible for this account: _____ Relationship to Patient: _____

Address: _____ Phone (____) _____

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

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 payers 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)

PATIENT'S DENTAL HISTORY

Why have you come to see us today? (e.g.: pain, checkup, etc.) _____

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

Are you nervous about seeing a dentist? Yes! No If yes, please tell us why: _____

Do you like your smile? 😊 Yes No

- | | 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 ever had any prolonged bleeding following extractions? | <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 had any orthodontic treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever experienced any of the following problems in your jaw? | | | 14. Do you wear dentures or partials?
If yes, date of placement _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Clicking | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain (joint, ear, side of face) | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Difficulty in opening or closing | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Difficulty chewing | <input type="checkbox"/> | <input type="checkbox"/> | | | |

PATIENT'S MEDICAL HISTORY

I consider my health to be (Please check one): Excellent Good Fair Poor

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Are you under medical treatment now? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?
If yes, please explain _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you use tobacco? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you use controlled substances? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you wear contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |

Doctor Notes Only

Initial Blood Pressure: _____

Medical health reviewed by Doctor.

X _____ Date _____

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

- | | Yes | No | | Yes | No | | Yes | No |
|------------------------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | Cardiac Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Easily Winded | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen Ankles | <input type="checkbox"/> | <input type="checkbox"/> | Angina | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting / Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Frequently Tired | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy / Convulsions | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement / Implant | <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis / Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problem | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS or HIV Infection | <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Problem | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Troubles / Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ | <input type="checkbox"/> | <input type="checkbox"/> |

7. Are you allergic to or have you had any reactions to the following?

- | | | |
|-------------------------------------|--------------------------|--------------------------|
| Local Anesthetics (e.g.: Novocaine) | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin or any other Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates | <input type="checkbox"/> | <input type="checkbox"/> |
| Sedatives | <input type="checkbox"/> | <input type="checkbox"/> |
| Iodine | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin/Ibuprofen | <input type="checkbox"/> | <input type="checkbox"/> |
| Any Metals | <input type="checkbox"/> | <input type="checkbox"/> |
| Latex Rubber | <input type="checkbox"/> | <input type="checkbox"/> |
| Other _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Women Only:

- | | | |
|---|--------------------------|--------------------------|
| a) Are you pregnant or think you may be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Are you nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Are you taking oral contraceptives? | <input type="checkbox"/> | <input type="checkbox"/> |

Please list all medications you are currently taking:

Patient's Signature: X _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS	NONE <input type="checkbox"/>	PATIENT'S SIGNATURE	BP	REVIEWED BY
_____	_____	NONE <input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	NONE <input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	NONE <input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	NONE <input type="checkbox"/>	_____	_____	Dr. _____