Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible 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)

First Name _____ *Middle Initial* ____ *Last Name* _____ *Birthdate* _____

Preferred Name _____ *SS#* _____ *Driver's License* _____

Address _____

Home Phone _____ *Cell Phone* _____ *E-mail* _____

Do you prefer to be contacted via: ___ *Home* ___ *Cell* ___ *Work* ___ *E-mail* ___ *Text*
(please rank your preferences 1st, 2nd, 3rd)

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

Patient's Employer _____ *Work Phone* _____ *Ext.* _____

Position with Company _____ *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 _____ *Birthdate* _____

Home Phone _____ *Cell Phone* _____ *E-mail* _____

Employer _____ *Work Phone* _____ *Ext.* _____ *SS#* _____

Position with Company _____ *Is this Person Currently a Patient in our Office?* ☐ *Yes* ☐ *No*

Insurance Information

Name of Insured _____ *Relationship to Patient* _____

Birthdate _____ *SS#* _____ *Insurance ID#* _____ *Work Phone* _____ *Ext.* ____

Name of Employer _____ *Union or Local #* _____ *Position* _____

Address of Employer _____ *City* _____ *State* _____ *Zip* _____

Insurance Company _____ *Group #* _____ *Policy ID #* _____

Insurance Co. Address _____ *City* _____ *State* _____ *Zip* _____

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

Name of Insured _____ *Relationship to Patient* _____

Birthdate _____ *SS#* _____ *Insurance ID#* _____ *Work Phone* _____ *Ext.* ____

Name of Employer _____ *Union or Local #* _____ *Position* _____

Address of Employer _____ *City* _____ *State* _____ *Zip* _____

Insurance Company _____ *Group #* _____ *Policy ID #* _____

Insurance Co. Address _____ *City* _____ *State* _____ *Zip* _____

Over Please

Patient Medical History

Physician _____ *Office Phone* _____ *Date of Last Exam* _____

	Yes	No
1. Are you under medical treatment now for other than routine check-ups? If yes, please explain _____	☐	☐
2. Have you been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
3. Has there been a change in your health in the past year? If yes, please explain _____	☐	☐
4. Are you taking any medication, including non-prescription medicine? If yes, please list _____	☐	☐
5. What pharmacy do you prefer? _____		
6. Has your physician recommended antibiotic coverage before dental treatment?	☐	☐
7. Do you have or have you had any of the following?	☐	☐

8. Are you allergic to or have you had any reactions to the following?	Yes	No
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Codeine	☐	☐
Acrylic	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____	☐	☐
9. Do you use tobacco?	☐	☐
10. Have you had an artificial joint placed? If yes, which joint & date _____	☐	☐
11. Women only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV Positive	☐	☐	Cold Sores/Fever Blisters	☐	☐	Heart Pace Maker	☐	☐	Rheumatic Fever	☐	☐
Alzheimer's Disease	☐	☐	Congenital Heart Disorder	☐	☐	Heart Trouble/Disease	☐	☐	Sinus Trouble	☐	☐
Anemia	☐	☐	Diabetes	☐	☐	Hemophilia	☐	☐	Sleep Apnea	☐	☐
Angina	☐	☐	Drug Addiction	☐	☐	Hepatitis A	☐	☐	Snore	☐	☐
Arthritis/Gout	☐	☐	Emphysema	☐	☐	Hepatitis B or C	☐	☐	Stomach Troubles/Ulcers	☐	☐
Artificial Heart Valve	☐	☐	Epilepsy or Seizures	☐	☐	High Blood Pressure	☐	☐	Stroke	☐	☐
Asthma	☐	☐	Excessive Bleeding	☐	☐	Kidney Problems	☐	☐	Swelling of limbs	☐	☐
Breathing Problems	☐	☐	Excessive Thirst	☐	☐	Liver Disease	☐	☐	Thyroid Disease	☐	☐
Bruise Easily	☐	☐	Fainting/Dizziness	☐	☐	Low Blood Pressure	☐	☐	Tuberculosis	☐	☐
Cancer	☐	☐	Frequent Headaches	☐	☐	Lung Disease	☐	☐	Tumors or Growths	☐	☐
Chemotherapy	☐	☐	Hay Fever/Allergies	☐	☐	Radiation Treatments	☐	☐	Ulcers	☐	☐
Chest Pains	☐	☐	Heart Attack/Failure	☐	☐	Renal Dialysis	☐	☐	Venerial Disease	☐	☐

Have you ever had any serious illness not listed above? ☐ *Yes* ☐ *No* *If yes, please explain* _____

Patient Dental History

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

Reason for today's appointment _____

1. Do your 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 mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you mouth breathe?	☐	☐
9. Do you clench or grind your 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. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile? If no, what would you like to change? _____	☐	☐

Payment is due in full at the time of treatment *unless prior arrangements have been approved.*
This office accepts insurance. I understand that I am responsible for payment of serviced rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.
I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

X _____

Signature of patient (or parent/guardian if minor) *Date*