



Welcome! Thank you for selecting our dental healthcare team!

We will strive to provide you with the best possible dental care.

To help 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)

Patient # _____
Date _____

Name _____ Soc. Sec. # _____ Birth date _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Cell Phone/Pager _____ E-Mail _____
 What is the best way to reach you? Phone Cell Phone Mail Other _____
 May we leave a message for you on your answering machine/ voice mail? Yes No
 Check Appropriate Box: Minor Single Married Divorced Separated
 If Student, Name of School/College _____ City _____ State _____ Full Time Part Time
 Patient's or Parent's Employer _____ Work Phone _____
 Business Address _____ City _____ State _____ Zip _____
 Spouse or Parent's Name _____ Employer _____ Work Phone _____
 Whom May We Thank For Referring You? _____
 Person to Contact in Case of Emergency _____ Phone _____

Responsible Party (Must Sign Form)

Name _____ Relationship to Patient _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Cell Phone/Pager _____ E-Mail _____
 Soc. Sec. # _____ Birth date _____ Driver's License # _____
 Employer _____ Work Phone _____

*****Is this Person or any immediate family member a patient of our office? Yes No *****

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash Personal Check Credit Card -Visa, MasterCard, Discover I wish to discuss the office's payment policy

Insurance Information (Please Present Card to be Copied)

Name of Insured _____ Relationship to Patient _____
 Birth date _____ Social Security # _____ Date Employed _____
 Name of Employer _____ Union or Local # _____ Work Phone _____
 Insurance Company _____ Have Benefits Been Used this Year? Yes No
Do you have additional insurance? Yes No If Yes, Complete the following:
 Name of Insured _____ Relationship to Patient _____
 Birth date _____ Social Security # _____ Date Employed _____
 Name of Employer _____ Union or Local # _____ Work Phone _____
 Insurance Company _____ Have Benefits Been Used this Year? Yes No

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No		Yes	No		Yes	No
1. Are you under medical treatment now?	<input type="checkbox"/>	<input type="checkbox"/>	9. Are you allergic to or have you had a reaction to the following?	<input type="checkbox"/>	<input type="checkbox"/>	11. Do you have or have you had any of the following?	<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"/>	Local Anesthetics (eg. Novocaine)	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking Fosamax, Aredia, Zometa, or similar?	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medication(s)? non-prescription medicine(s)? herbal remedies? What are you taking? _____	<input type="checkbox"/>	<input type="checkbox"/>	Other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/ Seizures	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you use controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/ Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you wearing contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have respiratory problems? Asthma Hay Fever/ Allergies Easily Winded Emphysema Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Iodine	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
8. Women Only: a) Are you pregnant/think you may be?	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>
b) Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>	Any Metals (ie. nickel, mercury)	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV infection	<input type="checkbox"/>	<input type="checkbox"/>
c) Are you taking oral contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>	Latex Rubber	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>
			Codeine	<input type="checkbox"/>	<input type="checkbox"/>	Mental Disorders	<input type="checkbox"/>	<input type="checkbox"/>
			Other (Please List) _____			Anemia	<input type="checkbox"/>	<input type="checkbox"/>
			10. Do you have heart problems? Have you had heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
			Angina	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
			Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement / Implant	<input type="checkbox"/>	<input type="checkbox"/>
			Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis or Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
			Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>
			Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
			Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
			Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea/ Snoring	<input type="checkbox"/>	<input type="checkbox"/>
			Ever taken Phen-Fen/Redux	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
			High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
			Other _____			Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
						Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
						Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Patient Dental History

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

	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 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 ever had any orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you wear dentures or partials? If yes, date of placement _____	<input type="checkbox"/>	<input type="checkbox"/>
	<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"/>
	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you like your smile?	<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 and the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I agree to notify the office of any changes to my health or patient information. I authorize the dentist to examine and treat me or my child, and release any information including diagnosis and records of treatment or exams 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 for 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. If I default on this agreement I agree to be responsible for all finance charges and/or collections and attorney expenses incurred. I am aware of the privacy practices and a Notice of Privacy Practices is available to me.

X

Signature of Patient (or parent if minor)

Date Signed

Updates/Comments: _____