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 needs, please fill out this form online, print it and bring it to your next appointment. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (CONFIDENTIAL)

Date		Patient Number		SSN	
Name				Birth Date	
Address					
City		State		Zip	
Home Phone		Cell Phone		Email	

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

Check Appropriate Box: ☐ Full Time Student ☐ Part Time Student ☐ Employed

College		City		State	
Employer					
Address					
City		State		Zip	
Spouse/Parent Name		Employer		Work Phone	
Who Referred You		Emergency Contact		Phone	

Responsible Party

Name		Relationship		Driver's License #	
Address					
Home Phone		Cell Phone		Email	
SSN		Birth Date		Financial Insitution	
Employer		Work Phone		☐ Current Patient	

Which form of payment do you prefer? ☐ Cash ☐ Check ☐ MasterCrad/VISA ☐ I wish to discuss the office's payment policy.

Insurance Information

Insured Name		Relationship		SSN	
Employer		Date Employed		Birth Date	
Address		Union/Local #		Work Phone	
City		State		Zip	
Insurance Company		Group #		Policy/ID #	
Address					
City		State		Zip	
Deductible		Used So Far		Max Benefit	

Patient Medical History

Physician _____ Phone _____ Last Exam Date _____

☐ Yes ☐ No 01. Are you under medical treatment now?

☐ Yes ☐ No 02. Have you been hospitalized for any surgical procedure within the last 5 years?

If Yes, please explain _____

☐ Yes ☐ No 03. Are you taking any medication(s), including non-prescription medicine?

If Yes, please list _____

☐ Yes ☐ No 04. Have you ever taken Fen-Phen/Redux?

☐ Yes ☐ No 05. Have you ever taken Fosamax, Boniva, Actonel or cancer medication containing bisphosphonates?

☐ Yes ☐ No 06. Have you ever taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?

☐ Yes ☐ No 07. Do you use tobacco?

☐ Yes ☐ No 08. Do you use controlled subtances?

☐ Yes ☐ No 09. Do you have or have you had any of the following?

☐ Yes High Blood Pressure	☐ Yes Kidney Disease	☐ Yes Cancer	☐ Yes Tuberculosis
☐ Yes Heart Attack	☐ Yes AIDS or HIV Infection	☐ Yes Arthritis	☐ Yes Radiation Therapy
☐ Yes Rheumatic Fever	☐ Yes Thyroid Problem	☐ Yes Joint eplacement or Implant	☐ Yes Glaucoma
☐ Yes Swollen Ankles	☐ Yes Heart Disease	☐ Yes Hepatitis/Jaundice	☐ Yes Recent Weight Loss
☐ Yes Fainting/Seizures	☐ Yes Cardiac Pacemaker	☐ Yes Sexually Transmitted Disease	☐ Yes Liver Disease
☐ Yes Asthma	☐ Yes Heart Murmur	☐ Yes Stomach Troubles/Ulcers	☐ Yes Heart Trouble
☐ Yes Low Blood Pressure	☐ Yes Angina	☐ Yes Chest Pains	☐ Yes Respiratory Problems
☐ Yes Epilepsy/Convulsions	☐ Yes Frequently Tired	☐ Yes Easily Winded	☐ Yes Mitral Valve Prolapse
☐ Yes Leukemia	☐ Yes Anemia	☐ Yes Stroke	☐ Yes Other
☐ Yes Diabetes	☐ Yes Emphysema	☐ Yes Hay Fever/Allergies	

☐ Yes ☐ No 10. Are you wearing contact lenses?

☐ Yes ☐ No 11. Are you allergic to or have you had any reactions to the following?

☐ Yes Local Anesthetics (Novocain)	☐ Yes Penicillin/Other Antibiotics	☐ Yes Sulfa Drugs	☐ Yes Barbiturates
☐ Yes Sedatives	☐ Yes Iodine	☐ Yes Aspirin	☐ Yes Any Metals
☐ Yes Latex Rubber	☐ Yes Other	Please list _____	

☐ Yes ☐ No 12. Do you have a persistent cough or throat clearing, not associated with a known illness (lasting more than 3 weeks)?

Women Only:

☐ Yes ☐ No 13. Are you pregnant or think you may be pregnant?

☐ Yes ☐ No 14. Are you nursing?

☐ Yes ☐ No 15. Are you taking oral contraceptives?

Patient Dental History

Previous Dentist _____ Location _____ Last Exam Date _____

☐ Yes ☐ No 01. Do your gums bleed while brushing or flossing?

☐ Yes ☐ No 02. Are your teeth sensitive to hot or cold liquids/foods?

☐ Yes ☐ No 03. Are your teeth sensitive to sweet or sour liquids/foods

☐ Yes ☐ No 04. Do you feel pain in any of your teeth?

☐ Yes ☐ No 05. Do you have any sores or lumps in or near your mouth?

☐ Yes ☐ No 06. Have you had any head, neck or jaw injuries?

☐ Yes ☐ No 07. Have you ever experienced any of the following problems in your jaw?

☐ Yes Clicking ☐ Yes Pain ☐ Yes Difficulty in opening/closing ☐ Yes Difficulty in chewing

☐ Yes ☐ No 08. Do you have frequent headaches?

☐ Yes ☐ No 09. Do you clench or grind your teeth?

☐ Yes ☐ No 10. Do you bite your lips or cheeks frequently?

☐ Yes ☐ No 11. Have you ever had difficult extractions in the past?

☐ Yes ☐ No 12. Have you ever had any prolonged bleeding after extractions?

☐ Yes ☐ No 13. Have you ever had any orthodontic treatment?

☐ Yes ☐ No 14. Do you wear dentures or partials? Placement Date _____

☐ Yes ☐ No 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?

☐ Yes ☐ No 16. 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.

_____

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

Doctor's Comments: