# 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)

SS # _____

Date _____

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Email _____ Cell Phone _____

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

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

Patient's or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

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 _____

Driver's License # _____ Financial Institution _____

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 ☐ Amex

## Insurance Information (Dental)

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS # _____ Date Employed _____

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

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. 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? | ☐ | ☐ |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____ | ☐ | ☐ |
| 3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____ | ☐ | ☐ |
| 4. Have you ever taken Phen-Fen/Redux? | ☐ | ☐ |
| 5. Do you use tobacco? | ☐ | ☐ |
| 6. Do you use controlled substances? | ☐ | ☐ |
| 7. Are you wearing contact lenses? | ☐ | ☐ |

| 9. 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 | ☐ | ☐ |
| Barbiturates | ☐ | ☐ |
| Sedatives | ☐ | ☐ |
| Iodine | ☐ | ☐ |
| Aspirin | ☐ | ☐ |
| Any Metals (e.g. nickel, mercury, etc.) | ☐ | ☐ |
| Latex Rubber | ☐ | ☐ |
| Other (please list) _____ | ☐ | ☐ |
| 10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 wks.) | ☐ | ☐ |
| 11. Women Only: | | |
| a) Are you pregnant or think you may be pregnant? | ☐ | ☐ |
| b) Are you nursing? | ☐ | ☐ |
| c) Are you taking oral contraceptives? | ☐ | ☐ |

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

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | ☐ | ☐ | Heart Disease | ☐ | ☐ | Chest Pains | ☐ | ☐ |
| Low Blood Pressure | ☐ | ☐ | Cardiac Pacemaker | ☐ | ☐ | Stroke | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Hay Fever / Allergies | ☐ | ☐ |
| Convulsions | ☐ | ☐ | Angina | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Fainting / Seizures | ☐ | ☐ | Heart Trouble | ☐ | ☐ | Glaucoma | ☐ | ☐ |
| Asthma | ☐ | ☐ | Heart Attack | ☐ | ☐ | Recent Weight Loss | ☐ | ☐ |
| Epilepsy | ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ | Liver Disease | ☐ | ☐ |
| Leukemia | ☐ | ☐ | Anemia | ☐ | ☐ | Ulcers | ☐ | ☐ |
| Cancer | ☐ | ☐ | Arthritis | ☐ | ☐ | Stomach Troubles | ☐ | ☐ |
| Radiation Therapy | ☐ | ☐ | Joint Replacement or Implant | ☐ | ☐ | Respiratory Problems | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Hepatitis / Jaundice | ☐ | ☐ | Emphysema | ☐ | ☐ |
| Kidney Diseases | ☐ | ☐ | Sexually Transmitted Disease | ☐ | ☐ | Other _____ | ☐ | ☐ |
| Thyroid Problem | ☐ | ☐ | AIDS or HIV Infection | ☐ | ☐ | | | |

# Patient Dental History

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

| | Yes | No |
|---|---|---|
| 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? | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| 8. Do you have frequent headaches? | ☐ | ☐ |
| 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? | ☐ | ☐ |

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

X _____

Signature of patient (or parent/guardian if minor)

Doctor's Comments _____

_____

_____ Signature _____ Date _____