

Thank You for Selecting Our Dental Team

To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Patient Number _____

Name _____ Date _____

Gender _____ Male / Female (Please Circle) Email Address _____

Soc. Sec. # _____ Birth date _____ Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box Minor Single Married Divorced Widowed 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 _____

Business Address _____ City _____ State _____ Zip _____

Whom May We Thank for Referring You?

Person to Contact in Case of
Emergency _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Employer _____ Work Phone _____ SS# _____

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

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birth date _____ Social Security # _____ Date Employed _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Do You Have Any Additional Insurance? Yes No If Yes, Complete the Following

Name of Insured _____ Relationship to Patient _____

Birth date _____ Social Security # _____ Date Employed _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID# _____
Ins. Co. Address _____ City _____ State _____ Zip _____
How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

1. Are you under medical treatment now? Yes No

2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? Yes No
If yes please explain. _____

3. Are you taking any medications including non-prescription medicine? Yes No
If yes, what medication(s) are you taking?

4. Have you ever taken Phen/Fen/Redux? Yes No 5. Do you use tobacco? Yes No

6. Do you use controlled substances? Yes No 7. Do you have or have you had any of the following?

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

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

- | | |
|--|--|
| Local Anesthetics (e.g. Novocain) <input type="checkbox"/> Yes <input type="checkbox"/> No | Penicillin or other Antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sulfa Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No | Barbiturates <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sedatives <input type="checkbox"/> Yes <input type="checkbox"/> No | Iodine <input type="checkbox"/> Yes <input type="checkbox"/> No |

Aspirin Yes No Any metals (e.g. nickel, mercury, etc.) Yes No
 Latex Rubber Yes No Other _____ Yes No

10. Women Only:

- a. Are you pregnant or think you may be pregnant? Yes No
 b. Are you nursing? Yes No
 c. Are you taking oral contraceptives? Yes No

Patient Dental History

Name of Previous Dentist _____ Date of Last Exam _____

Previous Dentist's Location _____ Date of Last Cleaning _____

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|--|--|
| 1. Do your gums bleed while brushing or flossing? <input type="checkbox"/> Yes <input type="checkbox"/> No | 2. Are your teeth sensitive to hot or cold liquids/foods? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? <input type="checkbox"/> Yes <input type="checkbox"/> No | 4. Do you feel pain to any of your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Do you have any sores or lumps in or near your mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No | 6. Have you had any head, neck or jaw injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have you ever experienced any of the following problems in your jaw? | |
| Clicking <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain (joint, ear, side of face) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Difficulty in opening or closing <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficulty in chewing <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Do you clench or grind your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. Have you ever had any difficult extractions in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Have you ever had any prolonged bleeding following extractions? <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Have you had any orthodontic treatment? <input type="checkbox"/> Yes <input type="checkbox"/> 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 diagnosis and the records of any treatment or examination rendered to me and/or my child during the period of such Dental care to third party 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)

Doctor's Comment _____ Signature _____ Date _____
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