

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.

Cell Phone _____

Soc. Sec. # _____

Date _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home 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 _____

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 _____ Home Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS# _____

Is this Person Currently a Patient in 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 I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ 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 _____

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 _____

Birthdate _____ Social Security # _____ 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 _____

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

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

Are you allergic to or have you had any reactions to the following?

	Yes	No
Local Anesthetics (eg. Novocaine).....	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or any other Antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa Drugs.....	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates.....	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives.....	<input type="checkbox"/>	<input type="checkbox"/>
Iodine.....	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin.....	<input type="checkbox"/>	<input type="checkbox"/>
Any Metals (e.g. nickel, mercury etc.).....	<input type="checkbox"/>	<input type="checkbox"/>
Latex Rubber.....	<input type="checkbox"/>	<input type="checkbox"/>
Other (please list) _____	<input type="checkbox"/>	<input type="checkbox"/>

Women Only:

a) Are you pregnant or think you may be pregnant?.....	<input type="checkbox"/>	<input type="checkbox"/>
b) Are you nursing?.....	<input type="checkbox"/>	<input type="checkbox"/>
c) Are you taking oral contraceptives?.....	<input type="checkbox"/>	<input type="checkbox"/>

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

Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?..... Yes No

If yes, please explain _____

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

If yes, what medication(s) are you taking? _____

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

Do you use tobacco?..... Yes No

Do you use controlled substances?..... Yes No

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

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

	Yes	No		Yes	No		Yes	No
High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles.....	<input type="checkbox"/>	<input type="checkbox"/>	Angina.....	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever / Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>
Fainting / Seizures.....	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy / Convulsions.....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss.....	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble.....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis / Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection.....	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem.....	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles / Ulcers.....	<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
Do your gums bleed while brushing or flossing?.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you have frequent headaches?.....	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to hot or cold liquids/foods?.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to sweet or sour liquids/foods?.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you bite your lips or cheeks frequently?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel pain to any of your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any difficult extractions in the past?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any sores or lumps in or near your mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any prolonged bleeding following extractions?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any head, neck or jaw injuries?.....	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any orthodontic treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever experienced any of the following problems in your jaw?			Do you wear dentures or partials?.....	<input type="checkbox"/>	<input type="checkbox"/>
Clicking.....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of placement _____		
Pain (joint, ear, side of face).....	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever received oral hygiene instructions regarding the care of your teeth and gums?.....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you like your smile?.....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing.....	<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. 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.

X

Signature of patient (or parent if minor)