



# 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 # \_\_\_\_\_

SS#/SIN \_\_\_\_\_

Date \_\_\_\_\_

Patient's Sex  F  M

## Patient Information (CONFIDENTIAL)

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Do you prefer to receive calls at your:  Home  Work  Cell Phone

Check Appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated

If Student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_  Full Time  Part Time

Patient or Parent/Guardian's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

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 \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Driver's License # \_\_\_\_\_ Birthdate \_\_\_\_\_ Financial Institution \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ SS#/SIN \_\_\_\_\_

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 \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID # \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

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 \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID # \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

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 \_\_\_\_\_

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 medication(s) including non-prescription medicine?.....  Yes  No  
If yes, what medication(s) are you taking? \_\_\_\_\_

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

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

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

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

8. 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 any reactions to the following?

Local Anesthetics (e.g. Novocain).....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Penicillin or any 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 .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any Metals (e.g. nickel, mercury, etc.).....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Latex Rubber.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other (please list) .....	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

11. 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 and Location \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

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

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

3. Are your teeth sensitive to sweet or sour liquids/foods?.....  Yes  No

4. Do you feel pain to any of your teeth?.....  Yes  No

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 .....	<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 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

**Payment is due in full at the time of treatment unless prior arrangements have been approved.**

This office accepts insurance. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

X

Signature of patient (or parent/guardian if minor)

Date