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)

Date _____

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip_____

Email: _____ SS# OR INS. ID #_____ Cell Phone: _____

Email appointment confirmation okay? ☐ Yes ☐ No Text messaging appointment confirmation okay? ☐ Yes ☐ No

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? _____

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

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Relationship

Name of Person Responsible_____ to Patient _____

Address _____ Home Phone_____

Driver's License # _____ Birthdate _____ Dental Insurance Carrier_____

Employer _____ Work Phone # _____

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

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, Please list_____		
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?	☐	☐

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

	Yes	No		Yes	No		Yes	No
AIDS or HIV Infection	☐	☐	Glaucoma	☐	☐	Lung / Respiratory Problems	☐	☐
Anemia	☐	☐	Hay Fever / Allergies	☐	☐	Mitral Valve Prolapse	☐	☐
Angina	☐	☐	Heart Attack	☐	☐	Radiation Therapy	☐	☐
Arthritis	☐	☐	Heart Disease	☐	☐	Recent Weight Loss	☐	☐
Asthma	☐	☐	Heart Murmur	☐	☐	Rheumatic Fever	☐	☐
Cancer / Tumors / Cysts	☐	☐	Heart Trouble	☐	☐	Sexually Transmitted Disease	☐	☐
Cardiac Pacemaker	☐	☐	Hemophilia	☐	☐	Stint/Shunt Artificial Heart Valves	☐	☐
Chest Pains	☐	☐	Hepatitis / Jaundice	☐	☐	Stomach Troubles / Ulcers	☐	☐
Diabetes	☐	☐	High Blood Pressure	☐	☐	Stroke	☐	☐
Easily Winded	☐	☐	History of Substance Abuse	☐	☐	Swollen Ankles	☐	☐
Emphysema	☐	☐	Joint Replacement or Implant	☐	☐	Thyroid Problem	☐	☐
Epilepsy / Convulsion	☐	☐	Kidney Diseases	☐	☐	Tuberculosis	☐	☐
Fainting / Seizures	☐	☐	Liver Disease	☐	☐	Other	☐	☐
Frequently Tired	☐	☐	Low Blood Pressure	☐	☐	_____		

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

	Yes	No
Local Anesthetics (e.g. Novocaine)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list)_____	☐	☐

10. Women Only:

a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐
c) Have you taken (bisphosphonate) medication for osteoporosis?	☐	☐

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, cold, sweet or sour liquids/foods?	☐	☐
3. Do you feel pain to any of your teeth?	☐	☐
4. Do you have any sores or lumps in or near your mouth?	☐	☐
5. Have you had any head, neck or jaw injuries?	☐	☐
6. Have you ever experienced any of the following problems in your jaw? (clicking, pain, difficulty chewing, opening or closing)	☐	☐
7. Do you clench or grind your teeth?	☐	☐
8. Have you ever had any difficult extractions in the past?	☐	☐
if yes please explain _____		
9. Have you ever had any prolonged bleeding following extractions?	☐	☐
10. Have you had any orthodontic treatment?	☐	☐
11. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		

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)

*Doctor's Signature*_____ *Date*_____

*Doctor's Comments*_____

*Assistant's Comments*_____