

Welcome

Thank you for selecting us.

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)

Name _____ Date _____
SS# _____ Birthdate _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Email _____ Cell Phone _____
Check Appropriate Box: Minor Single Married Separated Divorced Widowed
If Student, Name of School/College _____ City _____ State _____ Full Time Part Time
Patient 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 _____
(Other than spouse)

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Email _____ Cell Phone _____
Driver's License # _____ Birthdate _____
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 Third Party Financing e.g. Care Credit I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS# _____ Cell Ph. _____
Name of Employer _____ Work Phone _____
Insurance Company _____ Group # _____ Policy/ID# _____
Do you Have Any Additional Insurance? Yes No If Yes, Complete the Following
Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS# _____ Cell Ph. _____
Name of Employer _____ Work Phone _____
Insurance Company _____ Group # _____ Policy/ID# _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No		Yes	No			
1. Are you under medical treatment now?	<input type="checkbox"/>	<input type="checkbox"/>	9. Are you allergic to or have you had any reactions to the following:					
2. Have you ever been hospitalized for any surgery or serious illness within the last 5 years? If yes, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetics (e.g. Novocain)	<input type="checkbox"/>	<input type="checkbox"/>			
3. List any medications (including non-prescription) that you are taking including dosages and reason for medications: _____ _____ _____			Penicillin or other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>			
4. Have you ever taken Fen-Phen/Redux?	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>			
5. Do you use tobacco/E Cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>			
6. Do you use controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives	<input type="checkbox"/>	<input type="checkbox"/>			
7. Are you wearing contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	Iodine	<input type="checkbox"/>	<input type="checkbox"/>			
8. Do you have or have you had any of the following?			Aspirin	<input type="checkbox"/>	<input type="checkbox"/>			
Yes	No		Any Metals (e.g. nickel, mercury, etc.)	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Attacks or Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Latex Rubber	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>			
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	10. Women Only:					
Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant or think you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>			
Angina / Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>			
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking oral contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>			
High / Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	Yes	No		
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema / Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>
			Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
			Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Allergies	<input type="checkbox"/>	<input type="checkbox"/>
			Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
			Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
			Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
			AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Bisphosphonates e.g. Fosamax	<input type="checkbox"/>	<input type="checkbox"/>
			Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Patient Dental History

Name of Previous Dentist _____ Date of Last Exam / Treatment _____

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	11. Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	12. Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel pain to any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you ever had any difficult extractions in the past? Including any prolonged bleeding?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	14. Have you had any orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	15. Do you wear dentures, partials or retainers?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever experienced jaw problems e.g. Clicking / Pain / Difficulty in opening or closing / Difficulty in chewing	<input type="checkbox"/>	<input type="checkbox"/>	16. Have you ever received oral hygiene instructions?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you snore?	<input type="checkbox"/>	<input type="checkbox"/>	17. Do you like your smile?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have sleep apnea?	<input type="checkbox"/>	<input type="checkbox"/>	18. Any additional information we should be aware of?	<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/guardian if minor)

Doctor's Comments _____

Signature _____ Date _____