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.

Date _____

Patient Information (CONFIDENTIAL)

Name _____ *Nickname* _____ *Sex* ❑ *M* ❑ *F* *Birthdate* _____

Address _____ *City* _____ *State* _____ *Zip* _____

Home Phone# _____ *Cell Phone#* _____

Check Appropriate Box: ❑ *Minor* ❑ *Single* ❑ *Married* *Social Security #* _____

Patient's or Parent's Employer _____ *Work Phone* _____

Business Address _____ *City* _____ *State* _____ *Zip* _____

Spouse or Parent's Name _____ *Employer* _____ *Work Phone* _____

If Patient is a Student, Name of School/College _____ *City* _____ *State* _____

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* _____

Birthdate _____

Employer _____ *Work Phone* _____

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

Primary Dental Insurance Information

Name of Insured _____ *Relationship to Patient* _____

Birthdate _____ *Social Security or Insurance ID#* _____ *Date Employed* _____

Name of Employer _____ *Work Phone* _____

Address of Employer _____ *City* _____ *State* _____ *Zip* _____

Insurance Company _____ *Group#* _____ *Union or Local #* _____

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

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ❑ *Yes* ❑ *No* *IF YES, COMPLETE THE FOLLOWING:*

Name of Insured _____ *Relationship to Patient* _____

Birthdate _____ *Social Security or Insurance ID#* _____ *Date Employed* _____

Name of Employer _____ *Work Phone* _____

Address of Employer _____ *City* _____ *State* _____ *Zip* _____

Insurance Company _____ *Group #* _____ *Union or Local #* _____

Inc. Co. Address _____ *City* _____ *State* _____ *Zip* _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you taking any medication(s) Including non-prescription medicine? If yes, what medication)s) are you taking?	❒	❒
2. Do you smoke or use tobacco in any other form? If yes, What type?_____How much?_____	❒	❒
3. Do you drink alcoholic beverages? If yes, How much?_____	❒	❒
4. Do you use or have you ever used cocaine? If yes, date last used_____.	❒	❒
5. Are you taking or have you ever taken bisphosphonates (Fosamax, Boniva, Actonel) for Osteoporosis or cancer treatment?	❒	❒
6. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. novocaine)	❒	❒
Penicillin or other Antibiotics	❒	❒
Other	❒	❒
7. Women Only:		
a) Are you pregnant or think you may be pregnant?	❒	❒
b) Are you nursing?	❒	❒
c) Are you taking birth control pills?	❒	❒

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

	Yes	No		Yes	No		Yes	No
Hemophilia/Bleeding Problems	❒	❒	Heart Disease	❒	❒	Chest Pains	❒	❒
High Blood Pressure	❒	❒	Cardiac Pacemaker	❒	❒	Easily Winded	❒	❒
Rheumatic Fever	❒	❒	Heart Murmur	❒	❒	Stroke	❒	❒
Fainting/Seizures	❒	❒	Anemia	❒	❒	Hay Fever/Allergies	❒	❒
Asthma	❒	❒	Emphysema	❒	❒	Tuberculosis	❒	❒
Low Blood Pressure	❒	❒	Cancer	❒	❒	Radiation/Therapy	❒	❒
Epilepsy/Convulsions	❒	❒	Arthritis	❒	❒	Glaucoma	❒	❒
Diabetes	❒	❒	Joint Replacement or Implant	❒	❒	Liver Disease	❒	❒
Kidney Diseases	❒	❒	Hepatitis/Jaundice	❒	❒	Respiratory Problems	❒	❒
AIDS or HIV Infection	❒	❒	Sexually Transmitted Disease	❒	❒	Persistant Cough	❒	❒
Thyroid Problem	❒	❒	Stomach Troubles/Ulcers	❒	❒	Cough Up Blood	❒	❒
Artificial Heart Valve	❒	❒	Chemical Dependency	❒	❒	Other	❒	❒

Patient Dental History

Former Dentist _____ Date of last dental X-rays_____ Cleaning _____

Reason for today's visit _____

How often do you brush? _____ How often do you floss? _____

Please check any of the following conditions that apply to you:

- ❒ Bad Breath
- ❒ Bleeding gums
- ❒ Clicking or popping jaw
- ❒ Frequent headaches
- ❒ Grinding teeth
- ❒ Loose teeth or broken fillings
- ❒ Periodontal treatment
- ❒ Tooth pain
- ❒ Sensitivity to heat/cold
- ❒ Sensitivity to sweets
- ❒ Sensitivity when biting
- ❒ Sores or growths in your mouth

1. Are you satisfied with the appearance of your teeth?
   ❒ Yes ❒ No
2. Have you had any head, neck or jaw injuries?
   ❒ Yes ❒ No
3. Have you ever had a bad experience in a dental office?
   ❒ Yes ❒ No

Doctor's Comments_____

_____

_____

_____

_____

_____

Signature_____

Date_____

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.

_____

Signature of patient or parent if minor