

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 | | Yes | No |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? | <input type="checkbox"/> | <input type="checkbox"/> | 5. Are you taking or have you ever taken bisphosphonates (Fosamax, Boniva, Actonel) for Osteoporosis or cancer treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you smoke or use tobacco in any other form? If yes, What type? _____ How much? _____ | <input type="checkbox"/> | <input type="checkbox"/> | 6. Are you allergic to or have you had any reactions to the following? | | |
| 3. Do you drink alcoholic beverages? If yes, How much? _____ | <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetics (e.g. novocaine) | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you use or have you ever used cocaine? If yes, date last used _____ | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin or other Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Other | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 7. 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 birth control pills? | <input type="checkbox"/> | <input type="checkbox"/> |

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

- | | Yes | No | | Yes | No | | Yes | No |
|---------------------------------|--------------------------|--------------------------|------------------------------------|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|
| Hemophilia/Bleeding Problems .. | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | <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"/> |
| Fainting/Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever/Allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Radiation/Therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy/Convulsions | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement or Implant | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <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"/> | Persistent Cough | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Problem | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Troubles/Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | Cough Up Blood | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial Heart Valve | <input type="checkbox"/> | <input type="checkbox"/> | Chemical Dependency | <input type="checkbox"/> | <input type="checkbox"/> | Other | <input type="checkbox"/> | <input type="checkbox"/> |

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:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to heat/cold |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Tooth pain | <input type="checkbox"/> 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