Welcome!

Patient Information

Name _____ Date _____

Birth date _____ Social Security #: _____

Email: _____

Address _____ City _____ State _____ Zip _____

Preferred Phone # _____ home/work/cell (circle) Alt. Phone # _____ home/work/cell (circle)

Circle Appropriate Status: Minor Separated Single Married Divorced Widowed

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone# _____

Guardian Information (if patient is under age 18)

Contact _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Email _____

Preferred Phone # _____ home, work, cell (circle) Alt. Phone # _____ home, work, cell (circle)

Dental Insurance Information

Name of Insured _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____
(if different from responsible party)

Birth date _____ SS#/SIN _____ Insurance Company _____

Name of Employer _____ Union or Local # _____ Group # _____

Do You or the Patient Have Any Additional Dental Insurance?

If Yes, Please Complete the Following:

Name of Insured _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____
(if different from responsible party)

Birth date _____ SS#/SIN _____ Insurance Company _____

Name of Employer _____ Union or Local # _____ Group # _____

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 medicine(s) including non-prescription? If yes, please list. _____	☐	☐
4. Have you taken Fosamax, Boniva, Actonel or any medications containing bisphosphonates?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use any illicit drugs?	☐	☐

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

	YES	NO
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other _____		

9. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? ☐ ☐

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

	YES	NO		YES	NO		YES	NO		YES	NO
High Blood Pressure	☐	☐	Glaucoma	☐	☐	Chest Pains	☐	☐	Mental Health Problems	☐	☐
Heart Attack	☐	☐	Asthma	☐	☐	Easily Winded	☐	☐	Immunocompromised	☐	☐
Rheumatic Fever	☐	☐	Stroke	☐	☐	Heart Murmur	☐	☐	Respiratory Problems	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐	AIDS or HIV Infection	☐	☐
Fainting/Seizures	☐	☐	Leukemia	☐	☐	Tuberculosis	☐	☐	Anxiety/Nervous/Panic	☐	☐
Cardiac Pacemaker	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐	Osteoporosis/penia	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Heart Disease	☐	☐	Human Papillomavirus (HPV)	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐	Stomach Trouble/Ulcers	☐	☐
Frequently Tired	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐	Joint Replacement or Implant	☐	☐
Hepatitis- Type: _____	☐	☐	Depression	☐	☐	Thyroid Problem	☐	☐	Atrial Fibrillation (AFib)	☐	☐
Jaundice	☐	☐	Diabetes	☐	☐	Special Needs	☐	☐	Sexually Transmitted Disease	☐	☐
Mitral Valve Prolapse	☐	☐	Acid Reflux	☐	☐	Down Syndrome	☐	☐	Kidney Diseases	☐	☐

Other_____

WOMEN ONLY:	YES	NO		YES	NO		YES	NO
	Are you pregnant or think you may be?	☐	☐	Are you nursing?	☐	☐	Are you taking oral contraceptives?	☐	☐

	YES	NO
CHILDREN ONLY: Are Immunizations Current?	☐	☐

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 or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
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 experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in chewing	☐	☐

	YES	NO
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Have you had trouble getting numb?	☐	☐
11. Do you have dry mouth?	☐	☐
12. Do you have a strong gag reflex?	☐	☐
13. Do you get cold sores/fever blisters (HSV)?	☐	☐
14. Have you had any orthodontic treatment?	☐	☐
15. Do you wear dentures or partials?	☐	☐
16. Have you received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
17. Do you like your smile?	☐	☐

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 payers 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) & date

X_____ / /
Signature of Dentist & date