

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 _____ SS# _____

Address _____ City _____ State _____ Zip _____

Email _____ Home Phone _____ Cell Phone _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

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 _____

Email _____ Cell Phone _____

SS# _____ Birthdate _____

Employer _____ Work Phone _____ Driver's License# _____

Is this person currently a patient in our office? Yes No

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Date Employed _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

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# _____ Date Employed _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Over Please

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

<p>Are you under a physician's care now? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name _____</p> <p>Have you ever been hospitalized or had a major operation? If yes please explain _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you ever had a serious head or neck injury? If yes, _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you taking any medications, pills, or drugs? If yes, _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you on a special diet? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you use tobacco? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you use controlled substances? If yes, _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Women: Are you... <input type="checkbox"/> Pregnant/Trying to get pregnant? <input type="checkbox"/> Nursing <input type="checkbox"/> Taking oral contraceptives?</p> <p>Are you allergic to any of the following? <input type="checkbox"/> Aspirin <input type="checkbox"/> Penicillin <input type="checkbox"/> Codeine <input type="checkbox"/> Acrylic <input type="checkbox"/> Metal <input type="checkbox"/> Latex <input type="checkbox"/> Sulfa drugs <input type="checkbox"/> Local Anesthetics</p> <p>Other? If yes, _____</p>
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Do you have or have you had, any of the following?

<p>AIDS/HIV Positive <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Alzheimer's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anaphylaxis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Angina <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Arthritis/Gout <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Artificial Heart Valve <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Artificial Joint <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Date _____ Location _____</p> <p>Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blood Transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Breathing Problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Bruise Easily <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chest Pains <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cold Sores/Fever Blisters <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Congenital Heart Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Cortisone Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Drug Addiction <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Easily Winded <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Epilepsy or Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Excessive Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Excessive Thirst <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fainting Spells/Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequent Cough <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequent Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequent Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Genital Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Attack/Failure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Date _____</p> <p>Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Trouble/Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hepatitis A <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hepatitis B or C <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hives or Rash <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hypoglycemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Irregular Heartbeat <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Kidney Problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Lung Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pain in Jaw Joints <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Parathyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Radiation Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Recent Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Renal Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Shingles <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sickle Cell Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Spina Bifida <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stomach/Intestinal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Swelling of Limbs <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Thyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tumors or Growths <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Yellow Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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Have you ever had any serious illness not listed Yes No If yes _____

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

<p>1. Do your gums bleed while brushing or flossing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Are your teeth sensitive to hot or cold liquids/foods? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are your teeth sensitive to sweet or sour liquids/foods? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Do you feel pain to any of your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you have any sores or lumps in or near your mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you had any head, neck or jaw injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Have you ever experienced any of the following problems in your jaw? Clicking <input type="checkbox"/> Yes <input type="checkbox"/> No Pain (joint, ear, side of face) <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty in opening or closing <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty in chewing <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>8. Do you have frequent headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Do you clench or grind your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Have you ever had any prolonged bleeding following extractions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Have you had any orthodontic treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Do you wear dentures or partials? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of placement _____</p>
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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 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) Date _____