# 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.

Name of primary care provider _____

| | Yes | No |
|---|---|---|
| Have you ever been hospitalized or had a major operation? If yes, please explain _____ | ☐ | ☐ |
| Have you ever had a serious head or neck injury? If yes, _____ | ☐ | ☐ |
| Are you taking any medications, pills, or drugs? If yes, _____ | ☐ | ☐ |
| Are you on a special diet? | ☐ | ☐ |
| Do you use tobacco? | ☐ | ☐ |
| Do you use controlled substances? If yes, _____ | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Have you ever taken Fosamax, Boniva, Actonel or any other mediations containing bisphosphonates? | ☐ | ☐ |

Women: Are you...
☐ Pregnant/Trying to get pregnant? ☐ Nursing
☐ Taking oral contraceptives?

Are you allergic to any of the following? ☐ None
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa drugs ☐ Local Anesthetics

Other? If yes, _____

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

| | Yes | No | | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | ☐ | ☐ | Cortisone Medicine | ☐ | ☐ | Hemophilia | ☐ | ☐ | Recent Weight Loss | ☐ | ☐ |
| Alzheimer's Disease | ☐ | ☐ | Diabetes | ☐ | ☐ | Hepatitis A | ☐ | ☐ | Renal Dialysis | ☐ | ☐ |
| Anaphylaxis | ☐ | ☐ | Drug Addiction | ☐ | ☐ | Hepatitis B or C | ☐ | ☐ | Rheumatic Fever | ☐ | ☐ |
| Anemia | ☐ | ☐ | Easily Winded | ☐ | ☐ | Herpes | ☐ | ☐ | Rheumatism | ☐ | ☐ |
| Angina | ☐ | ☐ | Emphysema | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Scarlet Fever | ☐ | ☐ |
| Arthritis/Gout | ☐ | ☐ | Epilepsy or Seizures | ☐ | ☐ | High Cholesterol | ☐ | ☐ | Shingles | ☐ | ☐ |
| Artificial Heart Valve | ☐ | ☐ | Excessive Bleeding | ☐ | ☐ | Hives or Rash | ☐ | ☐ | Sickle Cell Disease | ☐ | ☐ |
| Artificial Joint | ☐ | ☐ | Excessive Thirst | ☐ | ☐ | Hypoglycemia | ☐ | ☐ | Sinus Trouble | ☐ | ☐ |
| Date _____Location _____ | | | Fainting Spells/Dizziness | ☐ | ☐ | Irregular Heartbeat | ☐ | ☐ | Spina Bifida | ☐ | ☐ |
| Asthma | ☐ | ☐ | Frequent Cough | ☐ | ☐ | Kidney Problems | ☐ | ☐ | Stomach/Intestinal Disease | ☐ | ☐ |
| Blood Disease | ☐ | ☐ | Frequent Diarrhea | ☐ | ☐ | Leukemia | ☐ | ☐ | Stroke | ☐ | ☐ |
| Blood Transfusion | ☐ | ☐ | Frequent Headaches | ☐ | ☐ | Liver Disease | ☐ | ☐ | Swelling of Limbs | ☐ | ☐ |
| Breathing Problems | ☐ | ☐ | Genital Herpes | ☐ | ☐ | Low Blood Pressure | ☐ | ☐ | Thyroid Disease | ☐ | ☐ |
| Bruise Easily | ☐ | ☐ | Glaucoma | ☐ | ☐ | Lung Disease | ☐ | ☐ | Tonsillitis | ☐ | ☐ |
| Cancer | ☐ | ☐ | Hay Fever | ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Chemotherapy | ☐ | ☐ | Heart Attack/Failure | ☐ | ☐ | Osteoporosis | ☐ | ☐ | Tumors or Growths | ☐ | ☐ |
| Chest Pains | ☐ | ☐ | Date _____ | | | Pain in Jaw Joints | ☐ | ☐ | Ulcers | ☐ | ☐ |
| Cold Sores/Fever Blisters | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Parathyroid Disease | ☐ | ☐ | Venereal Disease | ☐ | ☐ |
| Congenital Heart Disorder | ☐ | ☐ | Heart Pacemaker | ☐ | ☐ | Psychiatric Care | ☐ | ☐ | Yellow Jaundice | ☐ | ☐ |
| Convulsions | ☐ | ☐ | Heart Trouble/Disease | ☐ | ☐ | Radiation Treatments | ☐ | ☐ | | | |

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 _____

| | 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 ever experienced any of the following problems in your jaw? | | |
| Clicking | ☐ | ☐ |
| Pain (joint, ear, side of face) | ☐ | ☐ |
| Difficulty in opening or closing | ☐ | ☐ |
| Difficulty in chewing | ☐ | ☐ |
| 8. Do you have frequent headaches? | ☐ | ☐ |
| 9. Do you clench or grind your teeth? | ☐ | ☐ |
| 10. Have you ever had any prolonged bleeding following extractions? | ☐ | ☐ |
| 11. Have you had any orthodontic treatment? | ☐ | ☐ |
| 12. Do you wear dentures or partials? If yes, date of placement _____ | ☐ | ☐ |

# 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*