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)

Name________________ Nickname________ Birthdate________ SS#________
Address________________ City________ State________ Zip________
Check appropriate box: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed Home Phone________
If Student, Name of School/College________ City________ State____ ☐Full time ☐Part Time
Patient's or Parent's Employer________ Occupation________ Work Phone________
Business Address________ City________ State____ Zip________
Spouse or Parent'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________
Driver's License #________ Birthdate________ Employer________ Work Phone________
SS#________ Is This Person Currently a Patient in our Office? ☐Yes ☐No
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appt.
☐Cash ☐Personal Check Credit Card - ☐VISA ☐MasterCard ☐Discover

## INSURANCE INFORMATION

Name of Insured________ Relationship to Patient________
Birthdate________ SS#________ Name of Employer________
Work Phone________ Address of Employer________ City________ State____ Zip________
Insurance Company________ Group #________ Policy/ID#________
Insurance Co. Address________ City________ State____ Zip________
Insurance Co. Phone________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐Yes ☐No IF YES, COMPLETE THE FOLLOWING:
Name of Insured________ Relationship to Patient________
Birthdate________ SS#________ Name of Employer________
Work Phone________ Address of Employer________ City________ State____ Zip________
Insurance Company________ Group#________ Policy/ID#________
Insurance Co. Address________ City________ State____ Zip________
Insurance Co. Phone________

## PATIENT DENTAL HISTORY

Name of Previous Dentist & Location________ Date of Last Exam________

| | YES | NO |
|---|---|---|
| 1. Do your gums bleed while brushing or flossing? | ☐ | ☐ |
| 2. Are your teeth sensitive to hot/cold liquids/foods? | ☐ | ☐ |
| 3. Are your teeth sensitive to sweet liquids/foods? | ☐ | ☐ |
| 4. Do you feel pain to any of your teeth? | ☐ | ☐ |
| 5. Do you have or ever had any sores or lumps in or 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 chewing? | ☐ | ☐ |
| Difficulty in opening or closing? | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| 8. Do you have frequent headaches? | ☐ | ☐ |
| 9. Do you clench or grind your teeth? | ☐ | ☐ |
| 10. Do you bite your lips or cheeks frequently? | ☐ | ☐ |
| 11. Have you ever had any difficult extractions or any prolonged bleeding after extractions? | ☐ | ☐ |
| 12. Have you had any orthodontic treatment? | ☐ | ☐ |
| 13. Do you wear dentures or partials? | ☐ | ☐ |
| 14. Regular dental care in the past? | ☐ | ☐ |
| 15. Are you happy with the appearance of your teeth and smile? | ☐ | ☐ |
| 16. Bad experience related to dental treatment? | ☐ | ☐ |
| 17. Frightened by treatment? | ☐ | ☐ |
| 18. Would you prefer Nitrous Oxide? | ☐ | ☐ |

# 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 yrs? | ☐ | ☐ |

If yes, please explain____________________

______________________________

______________________________

| | YES | NO |
|---|---|---|
| 3. Are you taking any medication(s) including non-prescription medicine? | ☐ | ☐ |

If yes, what medication(s) are you taking?

| ***Drug*** | ***Current Med. Dose*** | ***Reason Taking*** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| | YES | NO |
|---|---|---|
| 4. Do you dip or chew tobacco? | ☐ | ☐ |
| 5. Do you smoke? | ☐ | ☐ |

If yes, # of packs/day?____________

\# of years used?__________

6. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | ☐ | ☐ | AIDS or HIV Infection | ☐ | ☐ | Liver Disease | ☐ | ☐ |
| Low Blood Pressure | ☐ | ☐ | Thyroid Problem | ☐ | ☐ | Hepatitis | ☐ | ☐ |
| Heart Disease | ☐ | ☐ | Cancer | ☐ | ☐ | Jaundice | ☐ | ☐ |
| Heart Pacemaker | ☐ | ☐ | Leukemia | ☐ | ☐ | Glaucoma | ☐ | ☐ |
| Mitral Valve Prolapse | ☐ | ☐ | Radiation Therapy | ☐ | ☐ | Respiratory Prob. | ☐ | ☐ |
| Heart Attack/Surgery | ☐ | ☐ | Chemotherapy | ☐ | ☐ | Emphysema | ☐ | ☐ |
| Heart Murmur | ☐ | ☐ | Blood Transfusion | ☐ | ☐ | Hay Fever/Allergy | ☐ | ☐ |
| Angina/Chest Pain | ☐ | ☐ | Kidney Diseases | ☐ | ☐ | Hives | ☐ | ☐ |
| Stroke | ☐ | ☐ | Epilepsy/Seizures | ☐ | ☐ | Asthma | ☐ | ☐ |
| Artificial Heart Valve | ☐ | ☐ | Fainting/Dizziness | ☐ | ☐ | Nervousness | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ | Hearing Loss | ☐ | ☐ | Bruise Easily | ☐ | ☐ |
| Sexually Transmitted Diseases | ☐ | ☐ | Stomach Prob/Ulcers | ☐ | ☐ | Diabetes | ☐ | ☐ |
| Artificial Joint/Implant | ☐ | ☐ | Psychiatric Treatment | ☐ | ☐ | Other__________ | | |

| 7. Are you allergic to or have you had any reactions to the following? | YES | NO |
|---|---|---|
| Local Anesthetics (i.e. Novocain) | ☐ | ☐ |
| Penicillin or any other Antibiotics | ☐ | ☐ |
| Sulfa Drugs | ☐ | ☐ |
| Codeine | ☐ | ☐ |
| Aspirin/Ibuprofen | ☐ | ☐ |
| Any Metals (i.e. nickel, mercury, etc.) | ☐ | ☐ |
| Latex Rubber | ☐ | ☐ |
| Other (please List)____________ | ☐ | ☐ |

________________________

________________________

| | YES | NO |
|---|---|---|
| 8. Do you use controlled substances/or have a drug addiction? | ☐ | ☐ |
| 9. *Women Only:* | | |
| (a) Are you pregnant or think you may be pregnant? | ☐ | ☐ |
| (b) Are you nursing? | ☐ | ☐ |
| (c) Are you taking oral contraceptives? | ☐ | ☐ |

# 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 other 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

Doctor's Signature________________________ Date__________________