

We would like to extend a warm welcome and thank you for choosing our dental team for your dental care. We will always strive to provide you with the best possible dental care and attention. Please fill out this form in its entirety. If you have any questions or need assistance, please ask us. We are always happy to help you.

**FOR YOUR WELLBEING AND SAFETY, PLEASE ANSWER ALL QUESTIONS THOROUGHLY**

**Patient Information (CONFIDENTIAL)**

Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F Social Security Number: \_\_\_\_\_  
Check appropriate box:  Minor  Single  Married  Divorced  Widowed  Separated  
Patient's Employer/School: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Years at Current Employer: \_\_\_\_\_  
Email: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_ Cell: \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_ or  Google  Facebook  TV  
Preferred method of contact:  Phone Call  Text  Email

**Responsible Party (ex: Parents, Spouse, Caregiver, Nursing home, P.O.A, etc.)**

Name of person responsible for this account: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Birth date: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work phone: \_\_\_\_\_  
Is this person currently a patient in our office?  Yes  No

**Dental Insurance Information: WE WORK WITH MOST PPO PLANS (NO HMO/MEDICAID/MEDICARE)**

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Subscriber's Birth date: \_\_\_\_\_ Member ID: \_\_\_\_\_ Employer: \_\_\_\_\_  
Insurance Co: \_\_\_\_\_ Phone: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

**Do you have additional dental insurance?  Yes  No If yes, please complete the following:**

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Subscriber's Birth date: \_\_\_\_\_ Member ID: \_\_\_\_\_  
Name of Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Name of Dental Insurance \_\_\_\_\_ Group Number: \_\_\_\_\_  
Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

## Dental History

How can we improve your smile today? \_\_\_\_\_

Are you in any dental discomfort? \_\_\_\_\_

Previous dental provider: \_\_\_\_\_

Date of last dental care: \_\_\_\_\_ Date of last x-rays: \_\_\_\_\_

Have you had problems with any of the following?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Bad Breath           | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Grinding/Clenching   | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Missing Teeth           |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Bleeding Gums        | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Hot/Cold Sensitivity | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Sweets Sensitivity      |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Broken Fillings      | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Loose Teeth          | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Clicking/Popping Jaw | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Difficulty Chewing   | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Sores/Growths in mouth  |

How do you feel about the appearance of your teeth? \_\_\_\_\_

Have you experienced an adverse reaction during/in conjunction with a medical/dental procedure?  Y  N

Any other important information about your dental health or previous treatment: \_\_\_\_\_

## Medical History

Physician's Name: \_\_\_\_\_ Date of last Physician visit: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you currently under physician care? If yes, describe: \_\_\_\_\_

Have you had any serious illnesses or operations? If yes, please describe: \_\_\_\_\_

Are you allergic to any medication? \_\_\_\_\_

Please list ALL medications you currently take: \_\_\_\_\_

Have you ever used biphosphonate medication? (Brand names include Fosamax, Actonel, Atelvia, Didronel, and Boniva)  Y  N

Women: Are you pregnant?  Y  N  Nursing?  Y  N  Taking birth control pills?  Y  N

Please check **Yes** or **No** if you've had any of the following. **PLEASE DO NOT LEAVE ANY UNCHECKED:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> AIDS/HIV Positive       | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Fainting                        | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Rapid Weight Change        |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Anaphylaxis             | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Food Allergies                  | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Radiation Treatment        |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Glaucoma                        | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Respiratory Disease        |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Headaches                       | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Rheumatic/Scarlet Fever    |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Heart Murmur                    | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Shingles                   |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Heart Problems                  | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Asthma                  | Describe: _____  | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Atrial Fibrillation     | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> High Cholesterol                | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Spina Bifida               |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Atopic (Allergy Prone)  | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Hemophilia/Abnormal Bleeding    | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Herpes                          | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Surgical Implants          |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Hepatitis                       | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Swelling of feet or ankles |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> High Blood Pressure             | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Thyroid disease            |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Jaw Pain                        | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Tobacco Habit              |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Kidney Disease                  | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Liver Disease                   | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Cortisone Treatments    | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Material Allergies              | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Ulcers/Colitis             |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Cough (persistent)      | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> (latex, wool, metal, chemicals) | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Cough up blood          | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Mitral Valve Prolapse           | Other: _____  |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Nervous Problems                | _____   |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Pacemaker/Heart Surgery         | Height: _____   |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Excessive Bleeding      | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Psychiatric Care                | Weight: _____   |

## Authorization and Release

I confirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my medical status. I understand this information will be used by the dentist to help determine appropriate and healthful treatment.

**I understand that I am responsible for payment of services rendered and also responsible for any co-payment and deductible that my insurance (if any) does not cover.** I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electric. By signing below, I have read and understand all of the above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_