

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 if different than above (**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 Policy Holder: _____ Relationship to Patient: _____

Policy Holder's Birth date: _____ Member ID: _____ Employer: _____

Insurance Co: _____ Phone: _____ Group Number: _____

Insurance Address: _____ City: _____ State: _____ Zip code: _____

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

Name of Policy Holder: _____ Relationship to Patient: _____

Policy Holder's Birth date: _____ Member ID: _____ Employer: _____

Insurance Co: _____ Phone: _____ 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
(latex, wool, metal, chemicals) | <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"/> Mitral Valve Prolapse | <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"/> Nervous Problems | Other: _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Pacemaker/Heart Surgery | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Psychiatric Care | Height: _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Excessive Bleeding | | 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: _____