WELCOME

Thank You for Selecting Our Dental Team.

To help us meet all your healthcare needs, please fill out this form completely (front and back) in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name _____ Date _____

Soc. Sec. #_____ Birthdate _____ Home Phone _____

Address _____ City_____ State _____ Zip _____

Check Appropriate Box: ❑ Minor ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

If Student, Name of School/College _____ City_____ State ____ ❑ Full-Time ❑ Part-Time

Patient's or Parent's Employer _____ 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 _____

Drivers License #_____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS# _____

Payment in full at each appointment. For your convenience, we offer the following methods of payment. Please check the option you prefer.

❑ Cash ❑ Personal Check ❑ Visa ❑ Mastercard ❑ Discover ❑ I wish to discuss the office payment policy.

Dental Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____

Name of Employer _____ Work Phone _____

Insurance Company_____ Group # _____

Do You Have Any Additional Insurance? ❑ Yes ❑ No If Yes, Complete the Following

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____

Name of Employer _____ Work Phone _____

Insurance Company_____ Group # _____

Over Please

Patient Medical History

Patient Name _____

Physician _____ Office Phone _____ Date of Last Exam _____

Are you allergic to or have you had any reactions to the following:	Yes	No
Local Anesthetics (eg. Novocain)	❑	❑
Penicillin or any other Antibiotics	❑	❑
Sulfa Drugs	❑	❑
Barbiturates	❑	❑
Sedatives	❑	❑
Iodine	❑	❑
Aspirin	❑	❑
Any Metals (eg. Nickel, mercury etc.)	❑	❑
Latex Rubber	❑	❑
Other _____	❑	❑
Women Only:		
Are you pregnant or think you may be pregnant?	❑	❑
Are you nursing?	❑	❑
Are you taking oral contraceptives?	❑	❑

	Yes	No
Are you under medical treatment now? If yes, please explain _____	❑	❑
Have you ever been hospitalized for any operation or serious illness within the last 5 years? If yes, please explain _____	❑	❑
Are you taking any medication(s) including non-prescription medicine? If yes, please list _____	❑	❑
Do you use tobacco?	❑	❑
Do you use controlled substances?	❑	❑

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

	Yes	No
High Blood Pressure	❑	❑
Heart Attack	❑	❑
Rheumatic Fever	❑	❑
Swollen Ankles	❑	❑
Fainting/Seizures	❑	❑
Asthma	❑	❑
Low Blood Pressure	❑	❑
Epilepsy/Convulsions	❑	❑
Leukemia	❑	❑
Diabetes	❑	❑
Kidney Disease	❑	❑

	Yes	No
AIDS or HIV Infection	❑	❑
Thyroid Problem	❑	❑
Heart Disease	❑	❑
Cardiac Pacemaker	❑	❑
Heart Murmur	❑	❑
Angina	❑	❑
Anemia	❑	❑
Emphysema	❑	❑
Cancer	❑	❑
Mitral Valve Prolapse	❑	❑
Liver Disease	❑	❑

	Yes	No
Arthritis	❑	❑
Joint Replacement or Implants	❑	❑
Hepatitis/Jaundice	❑	❑
Sexually Transmitted Disease	❑	❑
Stomach Troubles/Ulcers	❑	❑
Stroke	❑	❑
Hay Fever/Allergies	❑	❑
Tuberculosis	❑	❑
Radiation Therapy	❑	❑
Glaucoma	❑	❑
Other _____	❑	❑

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 liquid/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, or jaw pain?	❑	❑
7. Do you have frequent headaches?	❑	❑
8. Do you clench or grind your teeth?	❑	❑
9. Do you bite your lips or cheeks frequently?	❑	❑
10. Have you ever had any difficult extractions in the past?	❑	❑
11. Have you ever had any prolonged bleeding following extractions?	❑	❑
12. Have you had any orthodontic treatment (braces)?	❑	❑
13. Do you wear dentures or partials? If yes, date of placement?	❑	❑
14. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	❑	❑

15. Have you ever been treated or diagnosed with periodontal disease? If so, please explain. _____

16. What is most important to you about your dental health? _____

17. What is most important about a relationship with a dentist? _____

18. If there is anything you could change about your smile what would it be? _____

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on friendly, mutual understanding between provider and patient.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

X _____ Date _____

Signature of patient (or parent if minor)