Thank you for choosing our practice for your dental needs. We strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please complete this form in ink. If you have any questions or need assistance, we will be happy to help.

Patient Information (CONFIDENTIAL)

Today's Date: ______________

Name: *Last* ______________________________ *First* _____________________ *Preferred Name* ____________________

Address: ____ City: _______________ State: _______ Zip: __________

Birthdate: _____/______/______ SSN#: ______ - ______ - ______ Sex: ☐ Female ☐ Male

Home Phone (___) _______________ Cell Phone (___) _______________ Work Phone (___) _______________

Email ____________________________ Facebook ________________________ Instagram ________________________

I prefer to be contacted via: ☐ **Home** ☐ **Cell Phone** ☐ **Work** ☐ **Email** ☐ **No Preference**

Check Appropriate Box: ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered

Employer: _____________________________________ Occupation: ____

If Student, Name of School: _______________________ City: _______________ State: _____ ☐Full Time ☐Part Time

Person to Contact in Case of Emergency: ______________________________________ Phone (___) ______________

Whom May We Thank for Referring You to Us? ____

Insurance Information

Name of Insured: *Last* ____________________________ *First* ______________________ Relationship to Patient: _______

Birthdate: _____/______/______ SSN# ______ - ______ - ______ Driver's License # __________________

Employer: ____ Work Phone (___) _______________ x _______

Employer's Address: ____ Union or Local # ____________________

Insurance Company: ___________________________________ Group # ____________ Policy/ID # ________________

DO YOU HAVE ADDITIONAL INSURANCE? ☐ **Yes** ☐ **No** **IF YES, COMPLETE THE FOLLOWING:**

Name of Insured: *Last* ____________________________ *First* ______________________ Relationship to Patient: _______

Birthdate: _____/______/______ SSN# ______ - ______ - ______ Driver's License # __________________

Employer: ____ Work Phone (___) _______________ x _______

Employer's Address: ____ Union or Local # ____________________

Insurance Company: ___________________________________ Group # ____________ Policy/ID # ________________

Responsible Party

Name of person responsible for this account: _____________________________ Relationship to Patient: ____________

Address: ____ Phone (___) ___________________

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

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 payers 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 if minor)

Patient's Dental History

Why have you come to see us today? (e.g.: pain, checkup, etc.) ______________________________

Name of Previous Dentist and Location:______________________________ Date of Last Exam:______________

Are you nervous about seeing a dentist? ☐ Yes! ☐ No If yes, please tell us why: ______________________

Do you like your smile? ☺ ☐ Yes ☐ No

	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 chewing	☐	☐

	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 in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement____________________		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐

Patient's Medical History

I consider my health to be (Please check one): ☐ Excellent ☐ Good ☐ Fair ☐ Poor

	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 years?	☐	☐
If yes, please explain ______________________ ______________________________________		
3. Do you use tobacco?	☐	☐
4. Do you use controlled substances?	☐	☐
5. Do you wear contact lenses?	☐	☐

<u>Doctor Notes Only</u>

Initial Blood Pressure:

ASA:

Med Hx/Meds:

Allergies:

Medical health reviewed by Doctor.

X__________________________________Date__________

6. **Do you have or have you 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	☐	☐
AIDS or HIV Infection	☐	☐
Thyroid Problem	☐	☐
Heart Disease	☐	☐
Cardiac Pacemaker	☐	☐
Heart Murmur	☐	☐
Angina	☐	☐
Frequently Tired	☐	☐
Anemia	☐	☐
Emphysema	☐	☐
Cancer	☐	☐
Arthritis	☐	☐
Joint Replacement / Implant	☐	☐
Hepatitis / Jaundice	☐	☐
Sexually Transmitted Disease	☐	☐
Stomach Troubles / Ulcers	☐	☐
Chest Pains	☐	☐
Easily Winded	☐	☐
Stroke	☐	☐
Hay Fever	☐	☐
Tuberculosis	☐	☐
Radiation Therapy	☐	☐
Glaucoma	☐	☐
Recent Weight Loss	☐	☐
Liver Disease	☐	☐
Heart Trouble	☐	☐
Respiratory Problem	☐	☐
Mitral Valve Prolapse	☐	☐
Other ___________	☐	☐

7. **Are you allergic to or have you had any reactions to the following?**

	Yes	No
Local Anesthetics (e.g.: Novocaine)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin/Ibuprofen	☐	☐
Any Metals	☐	☐
Latex Rubber	☐	☐
Other ________________	☐	☐

Women Only:

	Yes	No
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

Please list all medications you are currently taking:

____

____

____

Patient's Signature: X____