Welcome

Thank you for selecting our dental office
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. If you have any questions or need assistance, please ask us – we will be happy to help.

Date _____

Patient Information (Confidential)

Name_____Birthdate_____Social Security #_____
Address_____City_____State_____Zip_____HomePhone_____
Email address _____ Cell Phone_____
Preferred Name_____Married____Single____Widowed____Divorced____
Patient's Employer_____Occupation_____WorkPhone_____
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_____

Responsible Party

Name of person responsible for account_____Relationship to patient_____
Address_____Home Phone_____
Driver's License #_____Birthdate_____Social Security #_____
Employer_____ Work Phone_____
Is this person a patient in our office? Yes_____No_____

Insurance Information

Name of Insured_____Relationship to patient_____
Birthdate_____Social Security #_____Date Employed_____
Name of Employer_____Work Phone_____
Address of Employer_____ City_____State_____Zip_____
Insurance Company_____Group #_____Military Rank_____
Ins. Co. Address_____City_____State_____Zip_____
Ins. Co. Phone #_____How much is the deductible?_____Max Annual Benefits?_____

Secondary Insurance

Name of Insured_____Relationship to patient_____
Birthdate_____Social Security #_____Date Employed_____
Name of Employer_____Work Phone_____
Address of Employer_____ City_____State_____Zip_____
Insurance Company_____Group #_____Military Rank_____
Ins. Co. Address_____City_____State_____Zip_____
Ins. Co. Phone #_____How much is the deductible?_____Max Annual Benefits?_____

Patient Dental History

	Yes	No
1. Do your gums bleed while brushing or flossing? _____	___	___
2. Are your teeth sensitive to hot, cold, sweet or sour? _____	___	___
3. Do you feel pain in any of your teeth? _____	___	___
4. Do you have any sores or lumps in or near your mouth?___	___	___
5. Have you had any head, neck or jaw injuries? _____	___	___
6. Have you ever experienced any of the following problems with your jaw?		
a) Clicking? _____	___	___
b) Pain (joint, ear, side of face)? _____	___	___
c) Difficulty in opening or closing? _____	___	___
d) Difficulty in chewing? _____	___	___
7. Do you have frequent headaches? _____	___	___
8. Do you clench or grind your teeth? _____	___	___
9. Have you ever had difficult extractions? _____	___	___
10. Have you ever had orthodontic work? _____	___	___
11. Have you ever had instruction on the correct method of brushing and flossing your teeth? _____	___	___
12. Have you ever had instruction on the care of your gums?__	___	___
13. Do you bite your lips or cheeks frequently? _____	___	___

(OVER PLEASE)

Patient Medical History

Medical Doctor_____Office Phone_____Date Last Seen_____

	Yes	No
1. Are you under medical treatment now?__ If yes, why?_____	___	___
2. Have you ever been hospitalized for any surgical operation or illness?_____ Please List _____	___	___
3. Are you taking any medications including non-prescription? _____ Please List _____ _____ _____ _____ _____	___	___
4. Do you use cigarettes or smokeless tobacco? If so, how much?_____	___	___
5. Do you use alcohol or other drugs?_____	___	___
6. Are you wearing contact lenses?_____	___	___

7. Are you allergic to or had reactions to the following?	Yes	No
Local Anesthetics_____	___	___
Antibiotics_____ Please List _____ _____	___	___
Sulfa Drugs_____	___	___
Barbiturates_____	___	___
Sedatives_____	___	___
Iodine_____	___	___
Aspirin_____	___	___
Latex_____	___	___
Other_____	___	___

8. Women Only:	Yes	No
a)Are you pregnant or think you may be pregnant?_____	___	___
b)Are you nursing?_____	___	___
c)Are you taking birth control pills?	___	___

9. Have you ever taken: Bisphosphonates(ex. Aredia/Fosamax) yes___no___ Phen-fen/Redux yes___ no___

10. Do you have or have you had any of the following? (If so, circle)

AIDS/HIV+/ARC Infection	Diabetes	Hepatitis/Jaundice	Radiation Therapy
Alcohol/Drug Abuse	Easily Winded	High Blood Pressure	Recent Weight Loss
Anemia	Emphysema	Hypoglycemia	Respiratory Problems
Angina	Epilepsy/Convulsions	Jaw Problems/TMJ/TMD	Rheumatic Fever
Arthritis/Rheumatism	Fainting/Seizures	Joint Replacement/Implant	Scarlet Fever
Asthma	Frequent Neck Pain	Kidney Disease	Shingles
Back Problems	Frequently Tired	Kidney Disease	Sinus Problems
Bleeding Problems	Glaucoma	Latex Allergy	Stomach Trouble/Ulcers
Cancer/Tumors	Hay Fever/Allergies	Leukemia	Swollen Ankles
Cerebal Palsy	Heart Attack/Stroke	Liver Disease	Thyroid Problem
Chemotherapy	Heart Disease/Trouble	Low Blood Pressure	Tuberculosis/TB
Chest Pains	Heart Murmur	Mitral Valve Prolapse	Venereal Disease/STD
Congenital Heart Defect	Heart Surgery/Pacemaker	Nervousness	Xray or Cobalt Treatment
Cosmetic Surgery	Heart Valve Replacement	Psychiatric Problems	Other_____

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 my child or me 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_____Date _____

Signature of Patient or Parent if minor

Doctor's Comments _____

_____

_____

_____

_____

_____

_____

Update (office use)

_____ ____/____/____

initals

_____

Comments

_____ ____/____/____

initals

_____

Comments

_____ ____/____/____

initals

_____

Comments