Welcome

Thank you for selecting us.

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

Patient Information (Confidential)

Patient Number _____

Name _____ Date _____

SS#/SIN _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Email _____ Cell Phone _____

Check appropriate box: _____ Minor _____ Single _____ Married _____ Separated _____ Divorced _____ Widowed

If student, Name of School/College _____ City _____ State _____ Full time__Part Time__

Patient or Patient/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Relationship

Name of person Responsible for this Account_____ To Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License# _____ Birthdate _____

Employer _____ Work Phone _____ SS# _____

Is this person Currently a patient in our office? _____ Yes _____ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
___ Cash ___Check ___ Credit Card: ___Visa ___ Mastercard ___Discover ____I wish to discuss the office payment policy.

Insurance Information

Relationship

Name of Insured _____ To Patient _____

Birthdate _____ SS#/SIN _____ Date employed_____

Name of Employer _____ Union or Local# _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group# _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How much is Your Deductible? _____ How much have you used? _____ Max. Annual Benefit _____

Do you have any additional insurance? _____ Yes _____ No If Yes, Complete the following:

Relationship

Name of Insured _____ To Patient _____

Birthdate _____ SS#/SIN _____ Date employed_____

Name of Employer _____ Union or Local# _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group# _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How much is Your Deductible? _____ How much have you used? _____ Max. Annual Benefit _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam_____

	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. Are you taking any medication(s) including non-prescription medicine?	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Do you use Tobacco?	☐	☐
6. So you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐

9. Are you allergic to or have you had any reactions to the following:	Yes	No
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other _____	☐	☐

	Yes	No
10. Do you have a persistent cough or throat clearing not associated with a known illness (last more than 3 weeks)?	☐	☐
11. Women Only:		
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

8. 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 Diseases	☐	☐
AIDS or HIV Infection	☐	☐
Thyroid Problem	☐	☐

	Yes	No
Heart Disease	☐	☐
Cardiac Pacemaker	☐	☐
Heart Murmur	☐	☐
Angina	☐	☐
Frequently Tired	☐	☐
Anemia	☐	☐
Emphysema	☐	☐
Cancer	☐	☐
Arthritis	☐	☐
Join Replacement or Implant	☐	☐
Hepatitis/Jaundice	☐	☐
Sexually Transmitted Disease	☐	☐
Stomach Troubles/Ulcers	☐	☐

	Yes	No
Chest Pains	☐	☐
Easily Winded	☐	☐
Stroke	☐	☐
Hay Fever/Allergies	☐	☐
Tuberculosis	☐	☐
Radiation Therapy	☐	☐
Glaucoma	☐	☐
Recent Weight Loss	☐	☐
Liver Disease	☐	☐
Heart Trouble	☐	☐
Respiratory Problems	☐	☐
Mitral Valve Prolapse	☐	☐
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 liquids/foods?	☐	☐
3. 2. 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 you mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in you jaw?		
Clicking	☐	☐
Pain (joint, ear side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in 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 you teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

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 payors and/or health practitioners. I authorize and request my insurance 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.

_____

Signature of Patient (or parent/guardian if minor)

Doctor's Comments _____

_____

_____ Signature _____ Date _____