Welcome

In order to help you reach and maintain maximum oral health, it is very important that we know all medical, dental and personal identifying information about you. Please fill out every section on this or any other form and provide us with the requested information. The better we communicate, the better we can care for you.

About You

Name: _____
LAST FIRST MI MR MRS MS DR

E-mail Address:_____

Preferred Nickname: _____ ☐ Male ☐ Female

DOB: ____/____/____ Age: ____ SS#: _____-____-_____

Address: _____
APT/CONDO #

_____
CITY ST ZIP

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

☐ Life Partner ☐ Engaged ☐ Minor

If patient is a minor, give parents or guardian's name & put their info in "spouse" area:

_____

Occupation: _____ How long there? _____

Employer: _____

Spouse's Name: _____

Spouse's Occupation: _____

Spouse's Employer: _____

Whom may we thank for referring you?: _____

Phone Numbers

Cell Phone: _____

Home Phone: _____

Work: _____

Where & When are best times to reach you? _____

Family Physician's Name: _____

Physician's Phone: (____)_____

IN CASE OF EMERGENCY, CONTACT:

Name: _____

Relation:_____

Home/Cell Phone: _____

Work Phone: _____

Dental Insurance

Primary Dental Insurance

Insurance Company: _____

Claims address: _____

Insurance Co. Phone #: (____)_____

Policy ID # _____

Group # _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____/_____/_____

Insured's SS #: _____

Insured's Employer:_____

Secondary Dental Insurance

Insurance Company: _____

Claims address: _____

Insurance Co. Phone #: (____)_____

Policy ID # _____

Group # _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____/_____/_____

Insured's SS #: _____

Insured's Employer:_____

Assignment & Release

I certify that, if applicable, I (or my dependent) have insurance coverage as indicated and assign directly to this office all insurance benefits otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. If I do not have insurance benefits I again acknowledge that I am solely responsible for all charges incurred and will pay for services in full when scheduling appointments and or upon treatment commencement.

_____
RESPONSIBLE PARTY SIGNATURE

_____ _____
RELATIONSHIP TO MINOR (IF APPLICABLE) DATE

Dental History

Reason for today's visit: _____

_____

What is the most important thing to you about your teeth?

_____

Is there anything you would like to change about your smile? _____

_____

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Former Dentist: _____

Date of last dental visit: _____

Date of last dental x-rays: _____

How often do you brush? _____

How often do you floss? _____

Your current dental health is:

☐ Good ☐ Fair ☐ Poor

Do you feel nervous about having dental treatment? ☐ Yes ☐ No

Have you ever had a bad experience in a dental office? ☐ Yes ☐ No

If yes, please describe:_____

Mark "Yes" or "No" to indicate if you presently have or previously had any of the following:

Bad Breath	☐ Yes ☐ No
Bite your lips or cheek regularly	☐ Yes ☐ No
Bleeding Gums	☐ Yes ☐ No
Blisters on lips or mouth	☐ Yes ☐ No
Chew on one side of mouth	☐ Yes ☐ No
Dry mouth	☐ Yes ☐ No
Food collection between teeth	☐ Yes ☐ No
Gums swollen or tender	☐ Yes ☐ No
Jaw pain or tiredness	☐ Yes ☐ No
Mouth breathing	☐ Yes ☐ No
Orthodontic Treatment	☐ Yes ☐ No
Periodontal Gum Treatment	☐ Yes ☐ No
Sensitivity to cold or hot	☐ Yes ☐ No

Have you experienced:

Clicking or popping of the jaw?	☐ Yes ☐ No
Grinding or Clenching Teeth	☐ Yes ☐ No
Pain? (Joint, ear, side of face)	☐ Yes ☐ No
Difficulty in opening/closing of mouth?	☐ Yes ☐ No
Have you ever had a serious/difficult problem associated with any previous dental work?	☐ Yes ☐ No

Medical History *Please complete all fields*

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

If so, please explain: _____

Have you taken oral or intravenous (I.V.) Bisphosphonates, such as Boniva or Fosamax, if so please list:_____

Are you taking any prescription/over-the-counter drugs? ☐ Yes ☐ No

List: _____

For Women:

Taking birth control pills?	☐ Yes ☐ No
Are you pregnant?	☐ Yes ☐ No
Are you nursing?	☐ Yes ☐ No

Are you allergic to any of the following:

Latex	☐ Yes ☐ No	Tetracycline	☐ Yes ☐ No
Penicillin	☐ Yes ☐ No	Codeine	☐ Yes ☐ No
Dental Anesthetic	☐ Yes ☐ No	Jewelry/Metals	☐ Yes ☐ No
Aspirin	☐ Yes ☐ No	Other	☐ Yes ☐ No
Erythromycin	☐ Yes ☐ No	_____	

Do you have or have you ever had any of the following disease or medical problems?

Heart Murmur	☐ Yes ☐ No
Mitral Valve Prolapse	☐ Yes ☐ No
Heart Problems	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No
Stroke	☐ Yes ☐ No
High/Low Blood Pressure	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No
HIV+/AIDS	☐ Yes ☐ No
Tuberculosis (TB)	☐ Yes ☐ No
Cancer/Chemotherapy	☐ Yes ☐ No
Tumors/Growths	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No
Tobacco/Smoker	☐ Yes ☐ No
Abnormal Bleeding	☐ Yes ☐ No
Alcohol/Drug Abuse	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No
Artificial Bones/Joints/Valves	☐ Yes ☐ No
Asthma	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No
Colitis	☐ Yes ☐ No

Difficulty Breathing	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No
Fainting Spells	☐ Yes ☐ No
Frequent Headaches	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No
Hay Fever	☐ Yes ☐ No
Hemophilia	☐ Yes ☐ No
Herpes	☐ Yes ☐ No
Hospitalized, if so reason_____	
_____	☐ Yes ☐ No
Kidney Problems	☐ Yes ☐ No
Liver Disease	☐ Yes ☐ No
Nervous/Anxious	☐ Yes ☐ No
Psychiatric Concerns	☐ Yes ☐ No
Rheumatic /Scarlet Fever	☐ Yes ☐ No
Seizures/Epilepsy	☐ Yes ☐ No
Sinus Problems	☐ Yes ☐ No
Thyroid Problems	☐ Yes ☐ No
Ulcers	☐ Yes ☐ No
HPV- Human Papillomavirus	☐ Yes ☐ No

Certification: I certify that the answers given are correct to the best of my knowledge.

Signature: _____ Date: _____

*Date:*_____ *Initials:*_____ *Date:*_____ *Initials:*_____ *Date:*_____ *Initials:*_____

*Update:*_____ *Update:*_____ *Update:*_____