*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 | ☐ | ☐ |
| 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? | ☐ | ☐ |

**Doctor Notes Only**
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 | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | ☐ | ☐ | Heart Disease | ☐ | ☐ | Chest Pains | ☐ | ☐ |
| Heart Attack | ☐ | ☐ | Cardiac Pacemaker | ☐ | ☐ | Easily Winded | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Stroke | ☐ | ☐ |
| Swollen Ankles | ☐ | ☐ | Angina | ☐ | ☐ | Hay Fever | ☐ | ☐ |
| Fainting / Seizures | ☐ | ☐ | Frequently Tired | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Asthma | ☐ | ☐ | Anemia | ☐ | ☐ | Radiation Therapy | ☐ | ☐ |
| Low Blood Pressure | ☐ | ☐ | Emphysema | ☐ | ☐ | Glaucoma | ☐ | ☐ |
| Epilepsy / Convulsions | ☐ | ☐ | Cancer | ☐ | ☐ | Recent Weight Loss | ☐ | ☐ |
| Leukemia | ☐ | ☐ | Arthritis | ☐ | ☐ | Liver Disease | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Joint Replacement / Implant | ☐ | ☐ | Heart Trouble | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ | Hepatitis / Jaundice | ☐ | ☐ | Respiratory Problem | ☐ | ☐ |
| AIDS or HIV Infection | ☐ | ☐ | Sexually Transmitted Disease | ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ |
| Thyroid Problem | ☐ | ☐ | Stomach Troubles / Ulcers | ☐ | ☐ | 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:**

| | | |
|---|---|---|
| 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_____