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

Soc. Sec. # _____

Patient Information (CONFIDENTIAL)

Date _____

Name_____ Birthdate _____ Home Phone_____

Address_____ City _____ State_____ Zip _____

Cell Phone _____E-Mail _____ Fax # _____

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

Patient's or Parents' Employer _____ Work Phone _____

Business Address _____ City _____ State ____ Zip _____

Spouse of Parent's Name _____ Employer _____ Work Phone _____

How did you find us? ☐ *Personal Reference (Name) _____* ☐ *Web Site* ☐ *Yellow Pages*

Person to contact in case of emergency _____ Phone _____

Responsible Party

Relationship

Name of person responsible for this account _____ to Patient _____

Address _____ Home Phone_____

Employer_____ Work Phone _____

Insurance Information

I understand that my insurance is an agreement between myself and my insurance company. I also understand that I am responsible for all balances regardless of my insurance. I also agree and understand that I am responsible for all fees resulting form any collection attempts. I assign all benefits from my insurance to my doctor.

Relationship

Name of insured _____ to Patient _____

Birthdate _____ Social Security # _____ Date Employed_____

Name of Employer _____ Work Phone _____

Address of Employer_____ City _____ State ____ Zip _____

Insurance Company _____Group # _____ Union or Local # _____

Ins. Co. Address _____City_____ State ____Zip _____

How much is your deductible? _____ Max. Annual Benefits_____

Over Please

Patient Medical History

Physician _____ *Office Phone* _____*Date of Last Exam*_____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Are you taking any medication(s) Including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____ _____		
3. Do you use tobacco?	☐	☐
4. Women Only: Are you pregnant or think you may be pregnant?	☐	☐

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

	Yes	No
Local anesthetics (e.g. novocaine)	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other _____	☐	☐

6. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	*Heart Disease*	☐	☐	*Easily Winded*	☐	☐
Heart Attack	☐	☐	*Cardiac Pacemaker*	☐	☐	*Stroke*	☐	☐
Rheumatic Fever	☐	☐	*Heart Murmur*	☐	☐	*Hay Fever/Allergies*	☐	☐
Swollen Ankles	☐	☐	*Angina*	☐	☐	*Tuberculosis*	☐	☐
Fainting/Seizures	☐	☐	*Frequently Tired*	☐	☐	*Radiation Therapy*	☐	☐
Asthma	☐	☐	*Anemia*	☐	☐	*Glaucoma*	☐	☐
Low Blood Pressure	☐	☐	*Emphysema*	☐	☐	*Recent Weight Loss*	☐	☐
Epilepsy/Convulsions	☐	☐	*Cancer*	☐	☐	*Liver Disease*	☐	☐
Leukemia	☐	☐	*Arthritis*	☐	☐	*Heart Trouble*	☐	☐
Diabetes	☐	☐	*Joint Replacement or Implant*	☐	☐	*Respiratory Problems*	☐	☐
Kidney Disease	☐	☐	*Hepatitis/Jaundice*	☐	☐	*Other*	☐	☐
AIDS or HIV Infection	☐	☐	*Stomach Trouble/Ulcers*	☐	☐	_____		
Thyroid Problem	☐	☐	*Chest Pains*	☐	☐			

Patient Dental History

	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 in 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?		
a) Clicking?	☐	☐
b) Pain (joint, ear, side of face)?	☐	☐
c) Difficulty in opening or closing?	☐	☐
d) 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 had any orthodontic work?	☐	☐
13. Have you ever had any prolonged bleeding following extractions?	☐	☐
14. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
15. Have you ever had instruction on the care of your gums?	☐	☐

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 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, and I will be responsible for the balance. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient or parent/guardian if minor

Doctor's Comments _____

_____

_____*Signature*_____*Date*_____