Thank You for Selecting Our Dental Team

To help us meet all of your healthcare needs, please fill out this form completely in ink.

Patient Information

Date_____

Name_____ If Student, Name of School/College_____

SS#_____ Birthdate_____ City_____ State_____

Address_____ City_____ Circle Appropriate Status: Full Time Part Time

State_____ Zip Code_____

Home Phone_____ Cell Phone_____

Email_____

Circle Appropriate Status:

Minor Single Married Separated
Divorced Widowed

Person to Contact in Case of Emergency_____

Telephone_____ Work_____ Cell_____

Responsible Party (if not same as above)

Name_____

Relationship to Patient_____

Birthdate_____

Address_____

Home Phone_____ Work_____ Cell _____

Employer Name_____

Address_____

Patient Dental History

Name of Previous Dentist_____ Date of Last Exam_____

Previous Dentist's Address_____ Date of Last Cleaning_____

Circle Appropriate Response:

1. Do your gums bleed while brushing or flossing? Y N
2. Are your teeth sensitive to hot or cold? Y N
3. Are your teeth sensitive to sweet or sour? Y N
4. Do you feel pain in any of your teeth? Y N
5. Do you have any sores or lumps in or near your mouth? Y N
6. Have you had any head, neck, or jaw injuries? Y N
7. Have you ever experienced any of the following problems in your jaw?
   - Clicking Y N
   - Pain (joint, ear, side of face) Y N
   - Difficulty in opening or closing Y N
   - Difficulty in chewing Y N
8. Do you have frequent headaches? Y N
9. Do you clench or grind your teeth? Y N
10. Do you bite your lips or cheeks ? Y N
11. Have you ever had any difficult extractions? Y N
12. Have you ever had any prolonged bleeding following extractions? Y N
13. Have you ever had orthodontic treatment? Y N
14. Do you wear dentures or partials? Y N
    If yes, date of placement_____
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? Y N
16. Do you like your smile? Y N

Patient Medical History

Physician_____ Office Phone_____ Date of Last Exam_____

Circle Appropriate Response:

1. Are you under medical treatment now? Y N
2. Have you been hospitalized for any surgical procedures or serious illness within the last 5 years? Y N
   If yes, please explain_____
_____
_____
_____
3. Have you ever taken Fen-Phen/Redux? Y N
4. Do you use tobacco? Y N
5. Do you use controlled substances? Y N
6. Are you wearing contact lenses? Y N
7. Do you have a persistent cough or throat clearing not associated with a known illness(lasting more than 3 weeks)? Y N
8. Have you ever taken Bisphosphonate Drugs? Y N
9. Do you take any type of blood thinners daily? (Aspirin, Coumadin, Alcohol, Plavix) Y N

Women only:

Are you pregnant or think you may be pregnant? Y N
Are you nursing? Y N
Are you taking oral contraceptives? Y N

10. Are you allergic to or have you had any reactions to the following:

Local Anesthetics (Novocain)	Y N
Penicillin or any other antibiotics	Y N
Sulfa Drugs	Y N
Barbiturates	Y N
Sedatives	Y N
Aspirin	Y N
Codeine	Y N
Latex	Y N
Any Metals (nickel, mercury)	Y N

Other_____

Patient Medical History (cont.)

Circle the Appropriate Response:

Do you have or have you ever had any of the following?

Anemia	Y N	Emphysema	Y N	Mitral Valve Prolapse	Y N
Angina	Y N	Epilepsy/Convulsions	Y N	Psychiatric Care	Y N
AIDS or HIV Infection	Y N	Fainting	Y N	Radiation Therapy	Y N
Anxiety	Y N	Frequently Tired	Y N	Recent Weight Loss	Y N
Arthritis	Y N	Glaucoma	Y N	Respiratory Problems	Y N
Asthma	Y N	Hay Fever/ Allergies	Y N	Rheumatic Fever	Y N
Blood Diseases	Y N	Heart Attack	Y N	Scarlet Fever	Y N
Cardiac Pace Maker	Y N	Heart Disease	Y N	Seizures	Y N
Cardiac Valve Replacement	Y N	Heart Murmur	Y N	Sexually Transmitted Disease	Y N
Cancer	Y N	Hepatitis/Jaundice	Y N	Sinus Pain	Y N
Chemotherapy	Y N	High Blood Pressure	Y N	Stomach Troubles/ Ulcers	Y N
Chronic Chest Pain	Y N	High Cholesterol	Y N	Stroke	Y N
Chronic Sore Throat	Y N	Joint Replacement/Implant	Y N	Swollen Ankles	Y N
Congenital Heart Disease	Y N	Kidney Disease	Y N	Thyroid Problem	Y N
Diabetes	Y N	Leukemia	Y N	Tuberculosis	Y N
Drug Addiction	Y N	Liver Disease	Y N		
Easily Winded	Y N	Low Blood Pressure	Y N	Other_____	

Please List Current Medications and Dosage

Please List Any Medical Changes

Have you ever taken Bisphosphonate Drugs? Yes or No

Insurance Information

Name of Insured_____ Birthdate_____

Subscriber ID #_____ Name of Employer_____

Employer Address_____

Insurance Company_____

Insurance Company Address_____

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. I agree to be responsible for payment of all services rendered on my behalf and my dependents.

Please read the following regarding broken appointment fees and finance charges.

There will be a $50.00 minimum charge for broken appointments and appointment cancellations without 24 hours notice. If you know that you cannot keep an appointment, please call and notify us as soon as possible. With 24hour notice you will avoid the broken appointment fee, and we may provide care for another patient during the time we set aside to care for you. If you have insurance, we will gladly process your claim. Your portion will be due on the day services are provided. Any balance 60 days past due will be assessed a finance charge of 1.5% a month.

Signature of patient (or parent/guardian) X_____ Date_____

Signature of Hygienist or Doctor _____