Welcome!

We appreciate the confidence you place in us to provide your dental services. Please take a few minutes to answer the following questions so we can better serve your dental needs.

PATIENT INFORMATION

Name:____________ Birthdate:____________ SS#/SIN:____________
Address:____________ City:____________ State:____________ Zip:____________
Email:____________ Cell/Day Phone:____________ Home Phone:____________
Check Appropriate Box: ◻ Minor ◻ Single ◻ Married ◻ Divorced ◻ Widowed ◻ Separated ◻ Long Term Partner
Employer:____________ Work Phone:____________
College Student Attending:____________ ◻ Full Time ◻ Part Time
Business Address:____________ City:____________ State:____________ Zip:____________
Parent or Spouse Name:____________ Employer:____________ Phone:____________
Who should we thank for referring you?____________
In case of emergency, who should we contact?____________ Phone:____________

RESPONSIBLE PARTY

Name of person responsible for this account:____________ Relationship:____________
Home Phone:____________ Day Phone:____________ Email:____________
Address:____________ City:____________ State:____________ Zip:____________
Driver's License #:____________ Birthdate:____________
Employer:____________ Work Phone:____________ SS#/SIN:____________
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.

◻ Cash ◻ Personal Check ◻ MasterCard ◻ VISA ◻ Discover ◻ I wish to discuss payment options

INSURANCE INFORMATION

Name of insured:____________ Relationship to patient:____________
Birthdate:____________ Date Employed:____________ SS#/SIN:____________
Name of employer:____________ Union or Local:____________ Work Phone:____________
Address of employer:____________ City:____________ State:____________ Zip:____________
Insurance Company:____________ Group Number:____________ Policy/ID#:____________
Insurance Company Address:____________ City:____________ State:____________ Zip:____________

ADDITIONAL INSURANCE

Name of insured:____________ Relationship to patient:____________
Birthdate:____________ Date Employed:____________ SS#/SIN:____________
Name of employer:____________ Union or Local:____________ Work Phone:____________
Address of employer:____________ City:____________ State:____________ Zip:____________
Insurance Company:____________ Group Number:____________ Policy/ID#:____________
Insurance Company Address:____________ City:____________ State:____________ Zip:____________

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PATIENT MEDICAL HISTORY

Physician:____ Office Phone:_________________ Date of last exam:______________

1. Are you under medical treatment now? □ Yes □ No

2. Have you ever been hospitalized for any surgeries or serious illnesses? □ Yes □ No
If yes please explain______________________
____

3. Are you taking any medications including non-prescriptions? □ Yes □ No
If yes please explain______________________
____

4. Have you ever taken Phen-Phen/Redux? □ Yes □ No

5. Have you ever taken Fosamax, Boniva, Actonel, or any cancer medications containing bisphosphonates? □ Yes □ No

6. Have you taken Viagra, Revatio, Cialis, or Levitra in the last 24 hours? □ Yes □ No

7. Have you traveled outside the U.S. in the last 12 months? □ Yes □ No
Do you have a cough? □ Yes □ No A fever? □ Yes □ No

8. Do you use Tobacco? □ Yes □ No

9. Do you use Alcohol? □ Yes □ No
Cocaine? □ Yes □ No
or other drugs? □ Yes □ No

10. Do you wear contact lenses? □ Yes □ No

11. Are you allergic or have you had a reaction to any of the following?
- Local anesthesia (Novocain) □ Yes □ No
- Penicillin or other antibiotics □ Yes □ No
- Sulfa drugs □ Yes □ No
- Barbiturates □ Yes □ No
- Sedatives □ Yes □ No
- Iodine □ Yes □ No
- Aspirin □ Yes □ No
- Metals □ Yes □ No
- Latex rubber □ Yes □ No
- Others please list:____________
____

12. Do you have a persistent or bloody cough, or a constant throat clearing lasting longer than three weeks? □ Yes □ No

13. Women only - are you…
- Pregnant □ Yes □ No
- Nursing □ Yes □ No
- Taking birth control pills □ Yes □ No

Please check any current or previous medical conditions that apply.

AIDS……………………………□
Allergies……………………………□
Anemia……………………………□
Angina……………………………□
Anxiety……………………………□
Arthritis……………………………□
Asthma……………………………□
Back Problems……………………………□
Bleeding Abnormally with Extractions or Surgery……………………………□
Cancer……………………………□
Cardiac Pacemaker……………………………□
Chemical Dependency……………………………□
Chest Pains……………………………□
Circulatory Problems……………………………□
Congenital Heart Lesions……………………………□
Diabetes……………………………□
Easily Winded……………………………□
Emphysema……………………………□
Epilepsy/Convulsions……………………………□

Fainting/Seizures……………………………□
Frequently Tired……………………………□
Glaucoma……………………………□
Hay Fever……………………………□
Heart Attack……………………………□
Heart Disease……………………………□
Heart Murmur……………………………□
Hepatitis Type ______……………………………□
Herpes……………………………□
High Blood Pressure……………………………□
HIV……………………………□
HPV……………………………□
Jaundice……………………………□
Joint Replacement……………………………□
Kidney Disease……………………………□
Leukemia……………………………□
Liver Disease……………………………□
Low Blood Pressure……………………………□
Mitral Valve Prolapse……………………………□

Sleep Apnea……………………………□
Psychiatric Care……………………………□
Radiation Therapy……………………………□
Recent Weight Loss……………………………□
Respiratory……………………………□
Rheumatic Fever……………………………□
Sexually Transmitted Infection……………………………□
Sinus Trouble……………………………□
Skin Rash……………………………□
Stomach Troubles/ Ulcers……………………………□
Stroke……………………………□
Swollen Ankles……………………………□
Swollen Neck Glands……………………………□
Thyroid Problems……………………………□
Tonsillitis or Tonsillectomy……………………………□
Tuberculosis……………………………□
Tumor or Growth……………………………□

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SLEEP HISTORY

1. Are you aware that you snore? □ Yes □ No
2. Are you often tired, fatigued or sleepy during the daytime? □ Yes □ No
3. Has anyone observed you stop breathing during sleep? □ Yes □ No

DENTAL HISTORY

1. Do your gums bleed, feel tender, or become swollen?________________________________
2. Does food catch between any of your teeth □ Yes □ No If yes, Where?________________________
3. Are your teeth sensitive to hot or cold? □ Yes □ No
4. Are your teeth sensitive to sweets? □ Yes □ No
5. Do you feel pain to any of your teeth? □ Yes □ No
6. Do you have broken teeth? □ Yes □ No If yes, where?________________________
7. Do you have missing teeth? □ Yes □ No If yes, where?________________________
   If yes, how were they replaced? □ Fixed Bridge □ Partial Denture □ Full Denture □ Implant (s)
   Are you happy with the replacement? □ Yes □ No
8. Do you have any sores or bumps in or around your mouth? If yes, where?________________________
9. Have you had any head, neck, or jaw injuries? □ Yes □ No
10. Have you experienced any of the following problems with your jaw?
    - Clicking □ Yes □ No
    - Pain (joint, ear, side of face) □ Yes □ No
    - Difficulty opening or closing □ Yes □ No
    - Difficulty chewing □ Yes □ No
11. Do you have frequent headaches? □ Yes □ No How often?________________________
12. Are you aware that you clench or grind your teeth? □ Yes □ No
13. Do you bite or chew on your lips or cheeks frequently? □ Yes □ No
14. Have you had any difficult extractions in the past? □ Yes □ No
15. Have you had prolonged bleeding following extractions? □ Yes □ No
16. Have you had orthodontic (braces) treatment? □ Yes □ No
17. Have you had your wisdom teeth extracted? □ Yes □ No
18. Have you had periodontal (gum) treatment? □ Yes □ No
19. Does dental treatment make you feel unusually frightened or anxious? □ Yes □ No
20. Is your water fluoridated? □ Yes □ No
21. Do you like your smile? □ Yes □ No

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 authorize the dentist to release any information including the diagnosis and the record 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.

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Patient/ Parent or Guardian Signature________________________________ Date:______________