Thank You for Choosing Our Dental Team

Patient Information (Confidential)

Name____ Date_____________________

SSN______________________ Birth Date_________________ Home Phone_______________

Address____________________________ City___________ State____ Zip Code____________

Email Address____ Cell Phone________________

Check Appropriate: __ Minor __ Single __ Married __ Separated __ Divorced __ Widowed

Patient or Parent/ Guardians Employer____

Work Phone____________ Business Address____

City___________ State_____ Zip Code___________

Spouse or Parent/Guardians Name ________________________ Employer_________________

Work Phone __________________

Who May We Thank For Referring You?

____

Emergency Contact Name ________________________________ Phone__________________

Responsible Party

Name of Person Responsible for this Account

____ Relationship to patient_____________

Home Phone _____________ Cell Phone _____________

Address____

Email _____________________________________ Driver's License #____________________

Birthdate _____________ SSN ______________ Financial Institution_____________________

Employer ____ Work Phone _______________

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, Payment in full at each appointment.

Cash___ Personal Check ___ Credit Card ___ VISA ___ MasterCard ___ Discover ___ CareCredit ___

Dental Insurance Information

Name of Subscriber ______________________________ Relationship to Patient _______________

Birthdate ___________ SSN ________________ Employer _________________________________

Union or Local # ________________ Work Phone _________________ Cell Phone_____________

Employer Address ____

Insurance Company ___________________________ Policy ID _____________________________

Group #__________________ Insurance Phone Number ___________________________________

Insurance Mailing Address ____

Do You Have Any Additional Dental Insurance? Yes ___ No ___ If yes, please complete the following

Name of Subscriber ______________________________ Relationship to Patient _______________

Birthdate ___________ SSN ________________ Employer _________________________________

Union or Local # ________________ Work Phone _________________ Cell Phone_____________

Employer Address ____

Insurance Company ___________________________ Policy ID _____________________________

Group #__________________ Insurance Phone Number ___________________________________

Insurance Mailing Address ____

Patient Medical History

Physician Name _____________________ Phone ______________ Date of Last Visit ___________

Preferred Pharmacy and Location ___________________________ Phone ____________________

1. Are you under medical treatment now? Yes ___ NO ___
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? Yes ___ No ___ If yes, please explain
   ____
3. Are you taking any medication(s) including non-prescription medication? Yes ___ No___
   If yes, please list any medications you are taking

____

____

4. Have you ever taken Fen-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?
7. Do you use tobacco? Yes ___ No ___
8. Do you use controlled substances? Yes ___ No ___
9. Do you wear contact lenses? Yes ___ No ___
10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? Yes ___ No ___
11. Women Only:
    - Are you pregnant or think you may be pregnant? Yes ___ No ___
    - If yes, how many weeks? _______
    - Are you nursing? Yes___ No ___
    - Are you taking oral contraceptives? Yes___ NO___

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

-Local Anesthetics (e.g. Novovain)	Yes ___ No___
-Sulfa Drugs	Yes ___ No ___
-Barbiturates	Yes ___ No ___
-Sedatives	Yes ___ No ___
-Iodine	Yes ___ No ___
-Aspirin	Yes ___ No ___
-Any Metals (e.g. nickel, mercury, etc.)	Yes ___ No___
-Latex Rubber	Yes___ No ___
-Food allergies	Yes___ No ___
If yes, please list ______________________________	
-Other Allergies ______________________________ ______________________________	

13. Do you have or have you ever had any of the following? Check all that apply.

__High blood pressure	__Asthma
__Heart Attack	__Low blood pressure
__Rheumatic Fever	__Leukemia
__Swollen Ankles	__Diabetes
__Fainting/Seizures	__Kidney Disease

__AIDS or HIV Infection
__Thyroid Problem
__Heart Disease
__Heart Murmur
__Cardiac Pacemaker
__Angina
__Frequently Tired
__Anemia
__Emphysema
__Cancer
__Arthritis
__Joint Replacement or Implant
__Hepatitis/Jaundice
__Sexually Transmitted Disease
__Stomach troubles/Ulcers

__Chest Pains
__Easily Winded
__Stroke
__Hay Fever/Allergies
__Tuberculosis
__Radiation Therapy
__Glaucoma
__Recent Weight Loss
__Liver Disease
__Heart Trouble
__Respiratory Problems
__Mirtral Valve Prolapse
__Other ________________________
____

Patient Dental History

Name Of previous Dentist___________________________ Date of Last Exam ______________________________
Previous Dentists Location ____

1. Do your gums bleed when flossing?
2. Are your teeth sensitive to hot or cold liquids/Foods? Yes ___ No ___
3. Are your teeth sensitive to sweet or sour liquids/foods? Yes ___ No ___
4. Do you feel pain in any of your teeth? Yes ___ No __
5. Do you have any sores or lumps in or near your mouth? Yes ___ No ___
6. Have you ever had any head, neck or jaw injuries? Yes ___ No ___
7. Have you ever experienced any of the following? Yes ___ No ___
   - -Clicking
   - -Pain (joint, ear, side of face) Yes___ No ___
   - -Difficulty in opening or closing Yes ___ No ___
   - -Difficulty in chewing Yes ___ No ___
8. Do you have frequent headaches? Yes ___ No ___
9. Do you clench or grind your teeth? Yes ___ No ___
10. Do you bite your lips or cheeks frequently? Yes ___ No ___
11. Have you ever had any difficult extractions in the past? Yes ___ No ___
12. Have you ever had any prolonged bleeding following extractions? Yes ___ No ___
13. Have you had any orthodontic treatment? Yes ___ No ___
14. Do you wear dentures or partials? Yes ___ No___
   - -If yes, date of placement? Yes ___ No ___

     ____
15. Have you ever received oral hygiene instructions? Yes___ No ___
16. Do you like your smile? 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 agree to be responsible for payment all services rendered on my behalf or my dependents.

Signature of patient (or parent/guardian if minor)