

# Thank You for Selecting Our Dental Team

To help us meet all your healthcare needs, please fill out this form completely in ink.  
If you have any questions or need assistance, please ask us and we will be happy to help.

## Patient Information (Confidential)

Name \_\_\_\_\_ Patient Number \_\_\_\_\_  
 Date \_\_\_\_\_  
 Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Check Appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated  
 If Student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  Full Time  Part Time  
 Patient's or Parent's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Whom May We Thank for Referring You? \_\_\_\_\_  
 Person to Contact in Case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

## Responsible Party

Name of Person Responsible for this Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Driver's License # \_\_\_\_\_ Birthdate \_\_\_\_\_ Financial Institution \_\_\_\_\_  
 Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ SSN # \_\_\_\_\_  
 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  Credit Card \_\_\_\_\_ Financing Available (with approved credit)

## Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_  
 Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID # \_\_\_\_\_  
 Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 How Much is Your Deductible \_\_\_\_\_ How Much Have You Used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_  
 E-Mail Address \_\_\_\_\_  
 Cell Phone # \_\_\_\_\_  
 When confirming appointments how do you prefer to be contacted?  Phone  E-Mail  Text Message  
 \_\_\_\_\_  
 Over Please

# 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 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 medicine?  Yes  No  
If yes, what medication(s) are you taking? \_\_\_\_\_

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

5. Do you use tobacco?  Yes  No

6. Do you use controlled substances?  Yes  No

7. Are you wearing contact lenses?  Yes  No

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

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

9. Are you allergic to or have you had any reactions to the following?  Yes  No

Local Anesthetics (e.g. novocaine)  Yes  No

Penicillin or other Antibiotics  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

Other \_\_\_\_\_  Yes  No

10. Women Only:

a) Are you pregnant or think you may be pregnant?  Yes  No

b) Are you nursing?  Yes  No

c) Are you taking oral contraceptives?  Yes  No

# Patient Dental History

Name of Previous Dentist \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

Previous Dentist's Location \_\_\_\_\_ Date of Last Cleaning \_\_\_\_\_

1. Do your gums bleed while brushing or flossing?  Yes  No

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 to any of your teeth?  Yes  No

5. Do you have any sores or lumps in or near your mouth?  Yes  No

6. Have you had any head, neck or jaw injuries?  Yes  No

7. Have you ever experienced any of the following problems in your jaw?

	Yes	No
Clicking	<input type="checkbox"/>	<input type="checkbox"/>
Pain (joint, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing	<input type="checkbox"/>	<input type="checkbox"/>

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 \_\_\_\_\_

15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?  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 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 agree to be responsible for payment of all services rendered on my behalf of my dependents.

X

Signature of patient (or parent if minor)

Doctor's Comments \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF  
PRIVACY PRACTICES**

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the above named practice's Notice of Privacy Practices.

Dated \_\_\_\_\_

\_\_\_\_\_  
Patient or Patient's Representative  
Print Patients Name \_\_\_\_\_  
If signed by Representative, state name of  
Representative \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_