WELCOME

TO HELP US MEET ALL OF YOUR DENTAL HEALTHCARE NEEDS, PLEASE FILL OUT THIS FORM COMPLETELY.
IF YOU HAVE ANY QUESTIONS OR NEED ASSISTANCE, PLEASE ASK US- WE WILL BE HAPPY TO HELP.

1 PERSONAL PATIENT INFORMATION

Name: _____ ____ _____ Preferred Name: _____ Today's Date: ___/___/_____
(First) (M.I.) (Last)

Birthdate: _____/_____/_____ SS#: _____-_____-_____ Male ◯ Female ◯

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: _____ Employer or School/College: _____

◯ Minor ◯ Single ◯ Married ◯ Divorced ◯ Widowed

How would you like to receive appointment reminders: (Check all that apply) ◯ Phone ◯ Text ◯ Email

Where do you prefer to receive calls: ◯ Home ◯ Cell ◯ Work

Parent or Guardian's Name: _____ Relationship to Patient: _____

Person to contact in case of an emergency: _____ Phone: _____

Referred by: (ex: Patient name/ online/ insurance) _____

2 RESPONSIBLE PARTY / DENTAL INSURANCE INFORMATION

Who is responsible for payment of the account?

Name: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip Code: _____

SS#: _____ Birthdate: ____/_____/_____ Driver's License#: _____

Primary
Employer: _____ Insurance Company: _____ ID#: _____ Group #: _____

Secondary (Spouse)
Employer: _____ Insurance Company: _____ ID#: _____ Group #: _____

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such dental care to third party payors and/or other 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.

3 MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health issues you may have, or medications you may be taking could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

Are you allergic to or have you had reactions to the following: PLEASE CHECK ALL THAT APPLY

- ☐ Local anesthetics like novocaine?
- ☐ Penicillin?
- ☐ Other Antibiotics? **Please list:**_____
- ☐ Sulfa Drugs?
- ☐ Barbiturates? ☐ Sedatives? ☐ Sleeping pills?
- ☐ Aspirin?
- ☐ Iodine?
- ☐ Other? **Please list:**_____

General Health questions:

YES NO

- ☐ ☐ Are you in good health?
- ☐ ☐ Have there been any changes in your general health within the past year?
- ☐ ☐ Are you now under the care of a physician?
  Date of your last physical exam: _____/_____/_____
  Physician's Name: _____
  Phone Number: _____
- ☐ ☐ Have you ever been hospitalized for any surgical operation or serious Illness? **Please explain:** _____
- ☐ ☐ Are you taking any medicine(s) including non-prescription medicine? **Please list:** _____
- ☐ ☐ Are you taking Fosamax or Boniva?
- ☐ ☐ Are you on Blood Thinners? **Please list:** _____
- ☐ ☐ Do you require **antibiotic pre-medication** before dental appointments?
- ☐ ☐ Have you had any abnormal bleeding?
- ☐ ☐ Do you bruise easily?
- ☐ ☐ Have you ever required a blood transfusion?
- ☐ ☐ Have you had a recent weight loss?
- ☐ ☐ Do you use tobacco?
- ☐ ☐ Do you use alcohol?
- ☐ ☐ Do you use cocaine or other drugs? **Please list:**_____
  Height: _____ Weight: _____

Women only:

- ☐ ☐ Are you pregnant or think you may be pregnant?
- ☐ ☐ Are you nursing?
- ☐ ☐ Are you taking birth control pills?

Do you currently have or have you ever had the following: PLEASE CHECK ALL THAT APPLY

- ☐ Rheumatic heart disease or rheumatic fever?
- ☐ Scarlet Fever?
- ☐ Heart trouble:
  ☐ Heart attack? ☐ Angina?
- ☐ Do you get short of breath when you lie down?
- ☐ Heart surgery?
  ☐ Bypass ☐ Pacemaker ☐ Stent placed Date:_____
- ☐ High Blood Pressure?
- ☐ Low Blood Pressure?
- ☐ Hepatitis? Type: _____
- ☐ Jaundice? ☐ Liver disease?
- ☐ Stroke?
- ☐ Sinus trouble?
- ☐ Lung or breathing problems?
  ☐ Asthma ☐ COPD ☐ Emphysema ☐ Sleep Apnea
- ☐ Diabetes?
  ☐ Diet controlled or ☐ Insulin Dependent
- ☐ AIDS? ☐ HIV?
- ☐ Thyroid problems?
- ☐ Seasonal allergies? ☐ Hives? ☐ Skin rash?
- ☐ Arthritis ☐ Rheumatism
- ☐ Joint replacement? ☐ Implant?- **Date:**_____
- ☐ Stomach ulcer?
- ☐ Kidney trouble?
- ☐ Tuberculosis?
- ☐ Persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?
- ☐ Cough that produces blood?
- ☐ Cancer?
- ☐ Sexually transmitted disease?
- ☐ Epilepsy? ☐ Seizures? ☐ Fainting spells?
- ☐ Multiple Sclerosis?
- ☐ Anemia?
- ☐ Leukemia?
- ☐ Glaucoma?
- ☐ Do you have any other disease /condition not listed previously? **Please List:**_____

Patient Dental History

Name of previous Dentist and location: _____ Date of last dental exam: _____

YES NO

- ☐ ☐ Do your gums bleed when flossing?
- ☐ ☐ Do you feel pain in any of your teeth?
- ☐ ☐ Are your teeth sensitive to: ☐ Hot ☐ Cold ☐ Sweet ☐ Sour
- ☐ ☐ Do you have any lumps or sores in or near your mouth?
- ☐ ☐ Do you bite your lips or cheeks frequently?
- ☐ ☐ Have you had any head, neck or jaw injuries?
- ☐ ☐ Have you experienced any of the following problems in your jaw?
  ☐ Clicking ☐ Difficulty chewing
  ☐ Difficulty opening/closing ☐ Pain

YES NO

- ☐ ☐ Have you ever had difficult extractions in the past?
- ☐ ☐ Have you ever had prolonged bleeding following extractions?
- ☐ ☐ Do you wear Dentures or Partials?
  Date of placement: _____
- ☐ ☐ Have you ever received oral hygiene instructions? regarding the care of your teeth and gums?
- ☐ ☐ Do you have frequent headaches?
- ☐ ☐ Do you clench or grind your teeth?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

X_____ **X**_____

SIGNATURE OF PATIENT /PARENT/GUARDIAN **DATE**

_____ _____

DR. SIGNATURE DATE