



**Thank you for selecting our dental healthcare team!
 We will strive to provide you with the best possible dental care.
 To help us meet all your dental healthcare needs, please fill
 out this form completely in ink. If you have any questions or
 need assistance, please ask us – we will be happy to help.**

Patient Information (CONFIDENTIAL) Male Female Date _____
 Name _____ Birthdate _____ SS# _____
 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 _____
 Email Address: _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
 Address _____ Home Phone _____
 Driver's License # _____ Birthdate _____
 Employer _____ Work Phone _____ SS # _____
 Is this Person Currently a Patient in our Office? Yes No

Insurance Information

Name of Insured _____ Relationship to Patient _____
 Birthdate _____ Social Security Number _____ Date Employed _____
 Name of Employer _____ Union or Local # _____ Work Phone _____
 Address of Employer _____ City _____ State _____ Zip _____
 Insurance Company _____ Group # _____ Policy/ID # _____
 Ins. Co. Address _____ City _____ State _____ Zip _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
 Birthdate _____ Social Security Number _____ Date Employed _____
 Name of Employer _____ Union or Local # _____ Work Phone _____
 Address of Employer _____ City _____ State _____ Zip _____
 Insurance Company _____ Group # _____ Policy/ID # _____
 Ins. Co. Address _____ City _____ State _____ Zip _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

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| <p>1. Are you under medical treatment now..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain _____</p> <p>3. Are you taking any medications including non-prescription medicine?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what medications are you taking? _____</p> <p>4. Do you use tobacco?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Have you ever taken a bisphosphonate such as Fosamax, Prolia, Zometa, or any others? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Do you have or have you had any of the following</p> | <p>7. Are you allergic to or have you had any reactions to the following?</p> <p>Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Penicillin or other Antibiotics..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any Metals (eg. nickel, mercury, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Latex Rubber <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sulfa Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Local Anesthetics (eg. Novocaine)..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Barbiturates <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sedatives <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Iodine..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other (please list) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Women Only:</p> <p>a) Are you pregnant or think you may be or pregnant?.... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) Are you nursing?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c) Are you taking oral contraceptives? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
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| | Yes | No | | Yes | No | | Yes | No |
|-----------------------------------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|------------------------------------|--------------------------|--------------------------|
| AIDS or HIV Infection | <input type="checkbox"/> | <input type="checkbox"/> | Cortisone Medicine | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> |
| Alzheimer's Disease | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A | <input type="checkbox"/> | <input type="checkbox"/> |
| Drug Addiction | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B or C..... | <input type="checkbox"/> | <input type="checkbox"/> | Renal Dialysis | <input type="checkbox"/> | <input type="checkbox"/> |
| Angina..... | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy or Seizures | <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | Artificial Heart Valve | <input type="checkbox"/> | <input type="checkbox"/> |
| Hives or Rash | <input type="checkbox"/> | <input type="checkbox"/> | Artificial Joint | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Thirst | <input type="checkbox"/> | <input type="checkbox"/> |
| Sickle Cell Disease | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Irregular Heartbeat | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Problems..... | <input type="checkbox"/> | <input type="checkbox"/> | Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | Stomach / Intestinal Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent Headaches | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer..... | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disease | <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest Pains..... | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack / Failure | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Cold Sores / Fever Blisters | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Pain in Jaw Joints..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Congenital Heart Disorder..... | <input type="checkbox"/> | <input type="checkbox"/> | Heart Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Parathyroid Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Trouble / Disease..... | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Care | <input type="checkbox"/> | <input type="checkbox"/> | Yellow Jaundice | <input type="checkbox"/> | <input type="checkbox"/> |
| C.Difficile..... | <input type="checkbox"/> | <input type="checkbox"/> | | | | Radiation Treatments | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | Anaphylaxis..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | Arthritis / Gout | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | Excessive Bleeding | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | Hypoglycemia | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | Blood Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | Breathing Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | Tumors or Growths..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | Ulcers | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | Infective Endocarditis | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | Other | <input type="checkbox"/> | <input type="checkbox"/> |

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

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|---|---|
| <p>1. Do your gums bleed while brushing or flossing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Are your teeth sensitive to hot or cold liquids/foods?? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are your teeth sensitive to sweet or sour liquids/foods?.. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Do you feel pain in any of your teeth?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you have any sores or lumps in or near your mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you had any head, neck or jaw injuries?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Have you ever experienced any of the following <input type="checkbox"/> Yes <input type="checkbox"/> No problems in your jaw?</p> <p>Clicking</p> <p>Pain (joint, ear, side of face)</p> <p>Difficulty in opening or closing</p> <p>Difficulty in chewing.....</p> | <p>8. Do you have frequent headaches?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Do you clench or grind your teeth?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Do you bite your lips or cheeks frequently? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Have you ever had any prolonged bleeding following extractions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Have you ever had any orthodontic treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Do you wear dentures or partials?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of placement.....</p> <p>14. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Do you like your smile? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
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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 or my dependents. I authorize the dentist staff to perform the diagnostic procedures and treatment necessary for proper dental care.

Signature of patient (or parent if minor) _____ Date _____