

Thank You for Selecting Our Dental Team

To help us meet all of 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 _____ Date _____
SSN # _____ Birthdate _____
Home Phone _____ Cell Phone _____
Address _____
City _____ State _____ Zip _____
Email _____
Circle Appropriate Choice: Minor • Single • Married • Separated • Divorced • Widowed
If Student, Name of College _____ City _____ State _____
Spouse/Parent/Guardian'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 _____
Address _____ Home Phone _____
Email _____ Cell Phone _____
Driver's License # _____ Birthdate _____ Financial Institution _____
Employer _____ Work Phone _____ SS # _____

For your convenience, we offer the following methods of payment. Please circle the option you prefer for payment in full at each appointment.

Cash • Personal Check • MasterCard • Visa • Discover • Care Credit

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS# _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____
Address _____ Policy/ID # _____

Do you have additional Insurance Yes • No (If Yes, Please Complete the Following)

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS# _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____
Address _____ Policy/ID # _____

Patient Medical History

Family Physician _____ Office Phone _____ Date of Last Exam _____

- Are you under medical treatment now? Yes No
- Have you ever been hospitalized for any surgical operations or serious illness within the last 5 years? Yes No
If yes, please explain _____
- Are you taking any medication(s) including non-prescription medicine? Yes No
If yes, what medications are you taking? _____
- Have you ever taken Fen-Phen/Redux? Yes No
- Have you ever taken Fosamax, Boniva, Actonel or any other cancer medications containing bisphosphonates? Yes No
- Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? Yes No
- Do you use tobacco? Yes No
- Do you use controlled substances? Yes No
- Do you have or have you ever had any of the following? Yes No
- Are you wearing Contact Lens? Yes No
- Are you Allergic to or have you had any reactions to the following?
Local Anesthetics (e.g. Novocain) Yes No
Penicillin or any 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
- Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? Yes No
- Woman Only:
Are you pregnant or think you may be pregnant? Yes No
Are you nursing? Yes No
Are you taking Oral Contraceptives? Yes No
- Do you need to be pre-medicated with Antibiotics? Yes No

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problem	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pace Maker	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No	Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No		

Patient Dental History

Name of previous Dentist _____ Date of Last Exam _____

Previous Dentist Location _____ Date of Last Cleaning _____

- Do your gums bleed while brushing or flossing? Yes No
- Are your teeth sensitive to hot or cold liquids/foods? Yes No
- Are your teeth sensitive to sweet or sour liquids/foods? Yes No
- Do you feel pain to any of your teeth? Yes No
- Do you have any sores or lumps in or near your mouth? Yes No
- Have you had any head, neck, or jaw injuries? Yes No
- Have you ever experienced any of the following problems in your jaw?
Clicking Yes No
Pain (joint, ear, side of face) Yes No
Difficulty in opening or closing Yes No
Difficulty in chewing Yes No
- Do you have frequent headaches? Yes No
- Do you clench or grind your teeth? Yes No
- Do you bite your lips or cheeks frequently? Yes No
- Have you ever had any difficult extractions? Yes No
- Have you ever had any prolonged bleeding following extractions? Yes No
- Have you had any orthodontic treatment? Yes No
- Do you wear dentures or partials? Yes No
If yes, date of placement _____
- Have you ever received oral hygiene instructions regarding the care of your teeth and gums? Yes No
- What would you change about 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 authorize and request my insurance company to pay directly to the dentist and 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.

X _____
Signature of patient (or parent/guardian if minor)

X _____
Doctor's Signature