

Welcome!

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.*

SSN/SIN: _____

Patient Information (CONFIDENTIAL)

Date: _____

Name _____ Home Phone _____ Cell Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

E-Mail _____ Birthdate _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

If Student, Name of School/College _____ City _____ State/Prov. _____ Full time

Part time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

E-Mail _____ Cell Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SSN/SIN _____

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 before appointment. Cash Credit Card: VISA MasterCard I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SSN/SIN _____ 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 _____

How Much is your Deductible? _____ How Much Have you Used? _____ Max. Annual Benefit _____

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

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SSN/SIN _____ 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 _____

How Much is your Deductible? _____ How Much Have you Used? _____ Max. Annual Benefit _____

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1. Are you under medical treatment now? Yes No
 *If yes, please explain: _____
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, pills, or drugs? Yes No
 *If yes, please explain: _____
4. Are you taking or have you ever taken medications for:
 a) Osteoporosis or blood thinners? Yes No
 b) Weight loss (diet pills), Fen-Phen/Redux? Yes No
5. Have you ever/do you use tobacco? Yes No
6. Have you ever/do you use controlled substances? Yes No

7. Are you allergic 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 (please list)..... Yes No

8. Women, Are You: _____

a) Pregnant/Think you may be pregnant? Yes No b) Nursing? Yes No c) Taking oral contraceptives? Yes No

Do you have or have you ever had any of the following?

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

- | | |
|---|---|
| 1. Do your gums bleed while brushing or flossing?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 8. Do you have frequent headaches?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Are your teeth sensitive to hot or cold liquids/foods?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. Do you clench or grind your teeth?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? <input type="checkbox"/> Yes <input type="checkbox"/> No | 10. Do you bite your lips or cheeks frequently?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Do you feel pain to any of your teeth?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Have you ever had any difficult extractions in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Do you have any sores or lumps in or near your mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Have you ever had any prolonged bleeding following extractions?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Have you had any head, neck, or jaw injuries?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Have you had any orthodontic treatment?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have you ever experienced any of the follow problems in your jaw? | 14. Do you wear dentures or partials?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Clicking?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | *If yes, date of placement: _____ |
| Pain (joint, ear, side of face)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Difficulty in opening or closing?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Do you like your smile?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Difficulty in chewing?..... <input type="checkbox"/> Yes <input type="checkbox"/> 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 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. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment. I acknowledge I have received a copy of the Dental Materials Fact Sheet dated October 2019.

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

X _____ Date _____
 Signature of dentist