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: _____

Patient Information (CONFIDENTIAL)

Date: _____

Name _____ Home Phone _____ Cell Phone _____

Address_____ City_____ State _____ Zip _____

E-Mail _____Birthdate_____

Check Appropriate Box❑ Minor❑ Single ❑ Married ❑ Divorced ❑ Widowed❑ Separated ❑ Full time

If Student, Name of School/College _____City_____ State _____ ❑ Part time

Patient or Parent/Guardian's Employer _____ Work Phone_____

Business Address_____ City_____ State _____Zip _____

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 _____

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 _____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 _____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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Patient Medical History

Physician_____ Phone_____ Date of Last Exam_____

	Yes	No
1. Are you under medical treatment now?.....	❑	❑
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?.....	❑	❑
3. Are you taking any medication(s), including non-prescription medicine, pills, or drugs?.....	❑	❑
4. Are you taking or have you ever taken medications for:		
a) Osteoporosis or blood thinners?	❑	❑
b) Weight loss (diet pills), Fen-Phen/Redux?.....	❑	❑
5. Have you ever/do you use tobacco?.....	❑	❑
6. Have you ever/do you use controlled substances?.....	❑	❑

*If yes, please explain:_____

7. Are you allergic or have you had any reactions to the following?

	Yes	No
Local Anesthetics (e.g. Novocaine).....	❑	❑
Penicillin or other antibiotics.....	❑	❑
Sulfa Drugs.....	❑	❑
Barbituates.....	❑	❑
Sedatives.....	❑	❑
Iodine.....	❑	❑
Aspirin.....	❑	❑
Any metals (e.g. nickel, mercury, etc).....	❑	❑
Latex Rubber.....	❑	❑
Other (please list)_____	❑	❑

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

Patient Dental History

Name of Previous Dentist and Location_____ Date of Last Exam_____

	Yes	No
1. Do your gums bleed while brushing or flossing?.....	❑	❑
2. Are your teeth sensitive to hot or cold liquids/foods?.....	❑	❑
3. Are your teeth sensitive to sweet or sour liquids/foods?	❑	❑
4. Do you feel pain to any of your teeth?.....	❑	❑
5. Do you have any sores or lumps in or near your mouth?	❑	❑
6. Have you had any head, neck, or jaw injuries?.....	❑	❑
7. Have you ever experienced any of the follow problems in your jaw?		
Clicking?.....	❑	❑
Pain (joint, ear, side of face)?.....	❑	❑
Difficulty in opening or closing?.....	❑	❑
Difficulty in chewing?.....	❑	❑
8. Do you have frequent headaches?.....	❑	❑
9. Do you clench or grind your teeth?.....	❑	❑
10. Do you bite your lips or cheeks frequently?.....	❑	❑
11. Have you ever had any difficult extractions in the past?	❑	❑
12. Have you ever had any prolonged bleeding following extractions?.....	❑	❑
13. Have you had any orthodontic treatment?.....	❑	❑
14. Do you wear dentures or partials?.....	❑	❑
If yes, date of placement_____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?.....	❑	❑
16. Do you like your smile?.....	❑	❑

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