Welcome to our office! We are honored you have chosen us as your dental provider and look forward to working with you. Please fill out this form completely to help us meet all your healthcare needs. If you have any questions or need assistance, please ask, we will be happy to help!

PATIENT INFORMATION

Date_____

Name_____ Birthdate_____ Home Phone_____
Address_____ City_____ State_____ Zip_____
Social Security #_____ ☐ male ☐ female Cell Phone_____
Please check appropriate box ☐ minor ☐ single ☐ married ☐ widowed ☐ separated
Patient's or Parent's Employer_____ Occupation_____ Work Phone_____
Business Address_____ City_____ State____ Zip_____
Spouse or Parent's Name_____ Employer_____ Work Phone_____
If patient is a student, name of college/school_____ City_____ State_____
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_____ City_____ State_____ Zip_____
Driver's license #_____ Birthdate_____ Is this person a current patient? Yes ☐ No ☐
Employer_____ Work Phone_____
Employer Address_____ City_____ State_____ Zip_____

DENTAL INSURANCE INFORMATION

Please note: If referred to a specialist, it is the patient's responsibility to verify coverage.

Name of insured_____ Relationship to patient_____
Birthdate_____ Social Security #_____ Date employed_____
Employer_____ Work Phone_____
Employer Address_____ City_____ State_____ Zip_____
Insurance Company_____ Group #_____ Union or local #_____
Ins. Co. Address_____ City_____ State_____ Zip_____
How much is your deductible?_____ How much have you used?_____ Max. annual benefit_____

Do you have additional coverage? Yes ☐ No ☐ ***If yes, please complete the following:***
Name of insured_____ Relationship to patient_____
Birthdate_____ Social Security #_____ Date employed_____
Employer_____ Work Phone_____
Employer Address_____ City_____ State_____ Zip_____
Insurance Company_____ Group #_____ Union or local #_____
Ins. Co. Address_____ City_____ State_____ Zip_____
How much is your deductible?_____ How much have you used?_____ Max. annual benefit_____

PATIENT MEDICAL HISTORY

Physician_____ Office Phone_____ Date of Last Exam_____

Please circle yes or no:

Yes No Are you under medical treatment now?
Yes No Have you ever been hospitalized for any surgical operation of serious illness within the last 5 years. If yes, please explain_____
Yes No Are you taking any medication(s) including non-prescription medicine? Please list: _____ _____
Yes No Have you ever taken Phen-Fen/Redux?
Yes No Do you use tobacco?
Yes No Do you use controlled substances?
Yes No Do you wear contact lenses?

Female patients only:

Yes No Are you pregnant?
Yes No Are you nursing?
Yes No Are you taking oral contraceptives?

Are you allergic to or have you had any reaction to the following? (Please circle if applies)

-Local anesthetic (novocaine)
-Penicillin or any other antibiotics
-Sulfa drugs
-Barbituates or Sedatives
-Iodine
-Aspirin
-Any metals (e.g. nickel, mercury)
-Latex rubber
-Other (please list) _____

Please circle any of the medical conditions that you have had or currently have:

High Blood Pressure	Heart Disease	Chest Pains	Kidney Disease
Heart Attack	Cardiac Pacemaker	Easily Winded	AIDS or HIV Infection
Rheumatic Fever	Heart Murmur	Stroke	Thyroid Problem
Swollen Ankles	Angina	Hayfever/Allergies	Hepatitis/Jaundice
Fainting/Seizures	Frequently Tired	Tuberculosis	Stomach Problems/Ulcers
Asthma	Anemia	Radiation Therapy	Respiratory Problems
Low Blood Pressure	Emphysema	Glaucoma	Mitral Valve Prolapse
Epilepsy/Convulsions	Sexually Transmittted Disease	Cancer	Recent Weight Loss
Leukemia	Arthritis	Liver Disease	Other_____
Diabetes	Joint Replacement or Implant	Heart Trouble	

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 foods or liquids?	___	___
3. Are your teeth sensitive to sweet or sour foods or liquids?	___	___
4. Do you feel any 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 following 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. Had any prolonged bleeding following an extraction?	___	___
13. Have you had any orthodontic treatment?	___	___
14. Do you wear dentures or a partial?	___	___
15. Do you like your smile?	___	___
16. Do you play sports? Please list.	___	___

Authorization and Release: I certify that I have read 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 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 practioners. 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 agree to inform the office of any changes to my medical status.

X _____ Date _____

Signature of patient (or parent if minor)