

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.*

Patient Information (CONFIDENTIAL)

Name _____ Birthday _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Email Address _____ Cell Phone _____

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?(OPTIONAL) _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

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

Address _____ Home Phone _____

Driver's License# _____ Birthday _____

Employer _____ Work Phone _____ SS# _____

Is this Person Currently a Patient in our Office? Yes No

Dental Insurance Information

If you have already faxed in your information, Dental Insurance information is not required.

Name of insured _____ Relationship to Patient _____

Birthday _____ Social Security # _____ 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 _____

Patient Medical History

Physician _____ Office Phone _____ Date of last Exam _____

<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? If yes, please explain. _____ _____</p> <p>3. Are you taking any medications(s) including non-prescription medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what medication(s) are you taking? _____ _____</p> <p>4. Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you use controlled substances? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Are you wearing contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. 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Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
Fainting/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
Heart Disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No																																																																																																																																																																																																		
Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
Joint Replacement or Implant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
Hepatitis / Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
Stomach Troubles / Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
Local Anesthetics(e.g. Novocaine)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No																																																																																																																																																																																																		
Penicillin or other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
Sedatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
Iodine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
Any Metals(e.g. nickel, mercury, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
Latex Rubber	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
Other (Please list) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
a) Are you pregnant or think you may be pregnant?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No																																																																																																																																																																																																		
b) Are you Nursing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		
c) Are you taking oral contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																																		

Patient Dental History

Name of Previous Dentist and Location _____

<p>1. Do your gum 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 to 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 problems in your jaw?</p> <table border="0"> <tr><td>Clicking</td><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> <tr><td>Pain(joint, ear, side of face)?</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Difficulty in opening or closing?</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Difficulty in chewing?</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table>	Clicking	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Pain(joint, ear, side of face)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in opening or closing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in chewing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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 difficulty extractions in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Have your ever had any prolonged bleeding following extractions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Have you had any orthodontic treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Do you wear dentures or partials? If yes, date placement _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. 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>16. Do you like your smile? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
Clicking	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No																	
Pain(joint, ear, side of face)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																	
Difficulty in opening or closing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																	
Difficulty in chewing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																	

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 payers 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 my behalf. or dependents.

X
Signature of Patient(or parent if minor) _____

Doctor's Comments _____
Signature _____ Date _____