

PATIENT INFORMATION

Welcome to our office! Please fill out this form completely in ink. All information is kept confidential. If you have any questions or need assistance, please ask us - we will be happy to help.

Today's Date: _____

Title: Mr. Mrs. Ms. Dr. Email Address: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Sex: _____ Age: _____ Birth Date: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Address: _____

If full time student, name of school: _____

Name of Spouse (parent if minor): _____

Person Responsible for Account: _____

How did you find us? _____

Additional Comments: _____

EMERGENCY INFORMATION

Name, Address, & Telephone of _____
a Relative not living with you _____

INSURANCE INFORMATION

PRIMARY CARRIER

Insured's Name: _____

Insurance Company: _____

Insurance Co. Address: _____

Insured's Employer: _____

Insured's

ID#: _____ Group # _____ Local# _____

SECONDARY CARRIER

If you have double insurance coverage complete this part.

Insured's Name: _____

Insurance Company: _____

Insurance Co. Address: _____

Insured's Employer: _____

Insured's

ID#: _____ Group # _____ Local# _____

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize my doctor to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to my doctor. I permit a copy of this authorization to be used in place of the original.

Patient Signature: _____ Date: _____

DENTAL HISTORY AND CONCERNS

Last Dental Visit: _____ Previous Dentist: _____

Was the treatment completed? Y N How often do you visit a dentist? Regularly Occasionally As Needed

Brushing Frequency: Once Daily Twice Daily After Every Meal Do you Floss? Yes No

DENTAL CONCERNS: CHECK ALL THAT APPLY

TEETH:

- | | | |
|---|--|--|
| <input type="checkbox"/> Broken or Chipped | <input type="checkbox"/> Loose Teeth | <input type="checkbox"/> Mouth Sores |
| <input type="checkbox"/> Crooked | <input type="checkbox"/> Tooth Pain | <input type="checkbox"/> Sensitive to Cold |
| <input type="checkbox"/> Decay | <input type="checkbox"/> Food Trap Areas | <input type="checkbox"/> Sensitive to Heat |
| <input type="checkbox"/> Difficulty Chewing | <input type="checkbox"/> Grinding or Clenching | <input type="checkbox"/> Sensitive to Bite |
| <input type="checkbox"/> Discolored | <input type="checkbox"/> Missing Teeth | <input type="checkbox"/> Sensitive to Sweets |
| <input type="checkbox"/> Loose/ Missing Filling | | |

GUMS:

- | | | |
|---|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Swollen |
| <input type="checkbox"/> Red (discolored) | <input type="checkbox"/> Sore | <input type="checkbox"/> Receding |
| <input type="checkbox"/> Abscessed | | |

FACIAL/JAW PAIN:

- | | | |
|--|--|---|
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Popping/ Clicking | <input type="checkbox"/> Jaw Locks Open/ Closed |
| <input type="checkbox"/> Avoid Certain Foods | <input type="checkbox"/> Pain In Temples | <input type="checkbox"/> Pain In Jaw |

OTHER CONCERNS:

- | | | |
|---|---|--|
| <input type="checkbox"/> Smoking/ Dipping | <input type="checkbox"/> Burning Tongue | <input type="checkbox"/> Chew On One Side |
| <input type="checkbox"/> Biting Cheeks | <input type="checkbox"/> Orthodontic Treatment | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> TMJ | <input type="checkbox"/> Whitening Teeth | <input type="checkbox"/> Teeth Straightening |
| <input type="checkbox"/> Tooth-Colored Fillings | <input type="checkbox"/> Tooth Replacement | <input type="checkbox"/> Retainer |
| <input type="checkbox"/> Wisdom Teeth | <input type="checkbox"/> Fractured Tooth Syndrome | <input type="checkbox"/> Dry Mouth |
| <input type="checkbox"/> Nail Biting | <input type="checkbox"/> Mouth Breathing | <input type="checkbox"/> Wisdom Teeth Extraction |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> CPAP | <input type="checkbox"/> Cosmetics |
| <input type="checkbox"/> Night Guard | <input type="checkbox"/> Implants, tooth # _____ | <input type="checkbox"/> Smile Makeover |
| <input type="checkbox"/> Limited Orthodontics | <input type="checkbox"/> Stain | <input type="checkbox"/> Dental Phobias |

MEDICAL HISTORY

How is your general health? Good Fair Poor

Are you currently under any treatment? Yes No If yes, please specify. _____

HAVE YOU EVER HAD,

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Dizziness or Fainting | <input type="checkbox"/> Heart Valve or Pacemaker | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Artificial Joint _____ (Date) | <input type="checkbox"/> Drug/Alcohol Addiction | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bleeding Problem or Anemia | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Herpes | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tumor or Growth |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Ulcers or G.I. Problems |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Frequent Thirst | <input type="checkbox"/> Kidney or Liver Disease | <input type="checkbox"/> Use Tobacco |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> X-ray/Chemotherapy |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Infective Endocarditis. |
| <input type="checkbox"/> Congenital Heart Problems | <input type="checkbox"/> HIV-AIDS-ARC | <input type="checkbox"/> Psychiatric Care | |
| <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> Heart Attack or Stroke | <input type="checkbox"/> Radiation/Chemotherapy | |

MEDICAL HISTORY (CONTINUED)

Do you have any other medical conditions that we should be aware of? _____

Who is your current Physician? _____

(If female) are you currently: Pregnant If so when is your Due Date? _____ Nursing On Birth Control

PLEASE LIST ALL PRESCRIPTIONS

1. _____
2. _____
3. _____
4. _____
5. _____

**Please be advised use of alcohol or recreational drugs combined with dental procedures may result in life threatening complications.*

HAVE YOU HAD AN ADVERSE REACTION OR ALLERGIES TO ANY MEDICATION OR SUBSTANCE?

- | | | |
|---------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Erythromycin |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Latex | <input type="checkbox"/> Nitrous Oxide |
| <input type="checkbox"/> Novocaine | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa Drugs |
| <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Valium | <input type="checkbox"/> Xylocaine |

Other _____

All of the above information is correct to the best of my knowledge.

Patient Signature: _____ Date: _____