Welcome

In order to help you reach and maintain maximum oral health, it is very important that we know all medical, dental and personal indentifying information about you. Please fill out every section on this or any other form and provide us with the requested information. The better we communicate, the better we can care for you.

About You

Name: ______________________________________
LAST FIRST MI MR MRS MS DR

Today's Date: __________ E-mail Address:______________

I prefer to be called: _______________ ☐ Male ☐ Female

Birthdate: ___/___/___ Age: _____ SS#: _____-____-_____

Address: ______________________________________
APT/CONDO #

____
CITY ST ZIP

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

☐ Life Partner ☐ Engaged ☐ Minor

If patient is a minor, give parents or guardian's name & put their info in "spouse" area:

____

Occupation: _______________ How long there? ______

Employer: ______________________________

Spouse's Name: ______________________________

Spouse's Occupation: ______________________________

Spouse's Employer: ______________________________

Whom may we thank for referring you?: ______________

Phone Numbers

Home Phone: (_____)__________ Cell: (_____)__________

Work Phone: (_____)_______________ Ext:_________

Spouse's Work: (_____)______________________

Where & When are best times to reach you? ______________

Family Physician's Name: ______________________

Physician's Phone: (_____)______________________

IN CASE OF EMERGENCY, CONTACT:

Name: ______________________________

Relation:______________________________

Home/Cell Phone: ______________________________

Work Phone: ______________________________

Dental Insurance

Primary Dental Insurance

Insurance Co. Name:______________________________

Insurance Co. Address: ______________________________

Insurance Co. Phone #: (_____)______________________

Group # (Plan, Local or Policy #): ______________________

Insured's Name: ______________ Relation:__________

Insured's Birthdate: ___/___/____

Insured's SS #: ______________________________

Insured's Employer:______________________________

Employer's Address: ______________________________

Employer Phone Number: ______________________________

Secondary Dental Insurance

Insurance Co. Name:______________________________

Insurance Co. Address: ______________________________

Insurance Co. Phone #: (_____)______________________

Group # (Plan, Local or Policy #): ______________________

Insured's Name: ______________ Relation:__________

Insured's Birthdate: ___/___/____

Insured's SS #: ______________________________

Insured's Employer:______________________________

Employer's Address: ______________________________

Employer Phone Number: ______________________________

Assignment & Release

I certify that, if applicable, I (or my dependent) have insurance coverage as indicated and assign directly to this office all insurance benefits otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. If I do not have insurance benefits I again acknowledge that I am solely responsible for all charges incurred and will pay for services in full when scheduling appointments and or upon treatment commencement.

____
RESPONSIBLE PARTY SIGNATURE

______________________________ ______________
RELATIONSHIP TO MINOR (IF APPLICABLE) DATE

Dental History

Reason for today's visit: ____________________________

What is the most important thing to you about your teeth?

____

Is there anything you would like to change about your smile? ☐ Yes ☐ No

If so what???________________________________

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Former Dentist: ____________________________

Date of last dental visit: ____________________________

Date of last dental x-rays: ____________________________

How often do you brush? ____________________________

How often do you floss? ____________________________

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you feel nervous about having dental treatment? ☐ Yes ☐ No

Mark "Yes" or "No" to indicate if you presently have or previously had any of the following:

Bad Breath	☐ Yes	☐ No
Bite your lips or cheek regularly	☐ Yes	☐ No
Bleeding Gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Food collection between teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Orthodontic Treatment	☐ Yes	☐ No
Periodontal Gum Treatment	☐ Yes	☐ No
Sensitivity to cold or hot	☐ Yes	☐ No

Have you experienced:

Clicking or popping of the jaw?	☐ Yes	☐ No
Grinding or Clenching Teeth	☐ Yes	☐ No
Pain? (Joint, ear, side of face)	☐ Yes	☐ No
Difficulty in opening/closing of mouth?	☐ Yes	☐ No
Have you ever had a serious/difficult problem associated with any previous dental work?	☐ Yes	☐ No

Medical History

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

If so, please explain: ____________________________

Have you taken oral or intravenous (I.V.) Bisphosphonates, such as Boniva or Fosamax, if so please list:____________________________

Are you taking any prescription/over-the-counter drugs? ☐ Yes ☐ No

Please list: ____________________________

For Women:

Are you taking birth control pills?	☐ Yes	☐ No
Are you pregnant?	☐ Yes	☐ No
Are you nursing?	☐ Yes	☐ No

Are you allergic to any of the following:

Latex	☐ Yes	☐ No	Tetracycline	☐ Yes	☐ No
Penicillin	☐ Yes	☐ No	Codeine	☐ Yes	☐ No
Dental Anesthetic	☐ Yes	☐ No	Jewelry/Metals	☐ Yes	☐ No
Aspirin	☐ Yes	☐ No	Other	☐ Yes	☐ No
Erythromycin	☐ Yes	☐ No	____________		

Do you have or have you ever had any of the following disease or medical problems?

Heart Murmur	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
High/Low Blood Pressure	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
HIV+/AIDS	☐ Yes	☐ No
Tuberculosis (TB)	☐ Yes	☐ No
Cancer/Chemotherapy	☐ Yes	☐ No
Tumors/Growths	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Tobacco/Smoker	☐ Yes	☐ No
Abnormal Bleeding	☐ Yes	☐ No
Alcohol/Drug Abuse	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Artificial Bones/Joints/Valves	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No
Colitis	☐ Yes	☐ No
Difficulty Breathing	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Fainting Spells	☐ Yes	☐ No
Frequent Headaches	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Herpes	☐ Yes	☐ No
Hospitalized, if so reason____________	☐ Yes	☐ No
Kidney Problems	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Nervous/Anxious	☐ Yes	☐ No
Psychiatric Concerns	☐ Yes	☐ No
Rheumatic /Scarlet Fever	☐ Yes	☐ No
Seizures/Epilepsy	☐ Yes	☐ No
Sinus Problems	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No
HPV- Human Papillomavirus	☐ Yes	☐ No

Certification: I certify that the answers given are correct to the best of my knowledge.

Signature: ____________________________ Date: ____________

*Date:*____________ *Initials:*________ *Date:*____________ *Initials:*________ *Date:*____________ *Initials:*________

*Update:*____________________ *Update:*____________________ *Update:*____________________