We would like to get to know you better! Appt Date: ________________

Name:____M.I.______Male ☐ Female ☐ D.O.B____________

Residence:____ City:__________________ St:_____ Zip Code:____________

If Child; Parent name: ___________________________________ Phone: ____________________Cell: ____________________

EMail: _____________________________________ Patient / Parent Social Security #: ___________________________________

Employer: ___________________________________Occupation____________________Employer Phone: __________________

Spouse / Parent Name:__________________________Employer:_____________________Employer Phone: __________________

Other Family Members In This Practice:____ Referred By: ______________________

Person responsible for dental investment?____

For insurance purposes:

Employee Name: ____DOB: ________ Relationship to Patient:__________

Name of Insurance: ______________________Insurance Telephone: _______________ID / Social Security #: _____________

Group or Policy #: __________________Insurance Address: ____

Are you covered by another plan?_______

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Are your teeth sensitive to:

Heat ☐ Cold ☐ Sweets ☐ Biting Pressure ☐

	Y	N
Does food catch between your teeth?	☐	☐
Do your gums bleed when brushing?	☐	☐
Have you noticed any gum swelling around any teeth?	☐	☐
Do you have an unpleasant taste or odor in your mouth?	☐	☐
Problems of the Jaw?		
Clicking of the Jaw	☐	☐
Pain (joints, ear, side of face)	☐	☐
Difficulty opening or closing	☐	☐
Difficulty chewing	☐	☐
Do you ever avoid any part of the mouth while brushing?	☐	☐
Are you dissatisfied with your teeth and their appearance?	☐	☐
Are you deeply concerned about the finance required to return your teeth to excellent dental health?	☐	☐
Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?	☐	☐
Do you smoke or use tobacco?	☐	☐
Have you ever had any teeth removed?	☐	☐
How long have these teeth been missing?_____________		
Do you feel you will eventually wear artificial dentures.	☐	☐
Do you have any fears?	☐	☐

When was your last dental appointment? _____________

Why did you leave your last dentist?________________

____

What is your present dental problem?_______________

____

Women only, are you:

Pregnant ☐ Nursing ☐ Taking Birth Control ☐

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my records (child's records) to carry out treatment, obtain payment, and for those activities and health care operations that are related to treatment or payment. I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or child's care) or payment for that care. **X**____

____

	Y	N
Are you currently under a physician's care?	☐	☐
Have you been hospitalized for surgery or illness?	☐	☐
Are you taking any medication(s), including non-prescription? If Yes, list medication and what you are taking it for:	☐	☐

____

____

____

Are you allergic to or had any reactions to the following?

Y	N		Y	N		Y	N	
☐	☐	Local anesthetics	☐	☐	Codeine	☐	☐	Sulfa drugs
☐	☐	Penicillin	☐	☐	Latex	☐	☐	Sedatives

Other:_______________________________________

Do you have or have you had any of the following?

Y	N.		Y	N	
☐	☐	High Blood Pressure	☐	☐	Low Blood pressure
☐	☐	Heart Attack	☐	☐	Heart Disease
☐	☐	Heart Murmur	☐	☐	Heart Trouble
☐	☐	Cardiac Pacemaker	☐	☐	Mitral Valve Prolapse
☐	☐	Angina	☐	☐	Stroke
☐	☐	Cancer/ Leukemia	☐	☐	Chemo / Radiation
☐	☐	Rheumatic Fever	☐	☐	Tuberculosis
☐	☐	Epilepsy/Convulsions	☐	☐	Fainting/ Seizures
☐	☐	Asthma	☐	☐	Emphysema
☐	☐	Kidney Disease	☐	☐	Hepatitis / Jaundice
☐	☐	Liver Disease	☐	☐	Thyroid Problem
☐	☐	Diabetes	☐	☐	Blood Transfusion
☐	☐	AIDS or HIV	☐	☐	Respiratory Problems
☐	☐	Stomach Troubles	☐	☐	Ulcers
☐	☐	Joint Replacement	☐	☐	Hay Fever / Allergies

Others:____

My consent to disclosure of records shall be effective until I revoke it in writing. I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor. I attest to the accuracy of the information on this page.

Signature:________________________________Date:________