Welcome

Thank you for selecting our dental healthcare team. To help us meet all your dental healthcare needs, please fill out this form completely.

Patient Information (Confidential)

Today's Date ________________

Name ______________________________________ Birthdate ______________ Age ________ Gender □ M □ F

(Last Name) *(First Name)*

Address ______________________________________ City ________________ Zip ________ SSN# ____________

Email ______________________________________ Home Ph ______________ Cell Ph ________________

Check Appropriate Box: □ *Minor* □ *Single* □ *Married* □ *Divorced* □ *Widowed* □ *Separated*

If Student, Name of School / College ______________________________________ Grade Level ____________

Patient's / Guardian's Employer ______________________________________ Work Ph ________________

Spouse of Patient / Guardian's Name ____

Person to Contact in case of emergency ______________________________________ Ph ________________

Who may we thank for referring you? ____

I will be paying for today's service by:

□ *Cash* □ *Check* □ *Credit Card* □ *Medicaid* □ *I would like to discuss payment options*

Responsible Party

Name of the Person Responsible for this Account ____________________________ Relationship to Patient ______________

Address (if different from above) ____

Email ______________________ Home Ph ______________________ Cell Ph ______________________

Driver's License # ______________________________________ Birthdate ______________________

Employer ______________________ Work Ph ______________________ SSN# ______________________

Is this person currently a Patient in our office? □ Yes □ No

Dental Insurance Information

Name of the Insured ______________________________ Relationship to Patient ______________________

Birthdate ______________________ SSN# ______________________ Date Employed ______________________

Name of Employer ______________________________________ Work Ph ______________________

Address of Employer ____

Insurance Company ______________________________ Insurance Company Ph ______________________

Group # ______________________ Policy # ______________________

Additional Dental Insurance

□ Yes □ No If yes, please complete the following:

Name of the Insured ______________________________ Relationship to Patient ______________________

Birthdate ______________________ SSN# ______________________ Date Employed ______________________

Name of Employer ______________________________________ Work Ph ______________________

Address of Employer ____

Insurance Company ______________________________ Insurance Company Ph ______________________

Group # ______________________ Policy # ______________________

Acknowledgment of Receipt of Notice of Privacy Practices

≈ You may refuse to sign this acknowledgment ≈

I, ________________________, have read a copy of this office's Notice of Privacy Practices and this acknowledgement will be kept on record for the following mentioned patient.

______________________________ ______________

(signature of patient or guardian) (Date)

Patient Name: ______________________________________

Patient Medical History

Physician's Name ________________________________

Office Phone ________________________ Date of Last Exam ________________________________

	YES	NO
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness with the last 5 years? If yes, please explain. ____________	☐	☐
3. Are taking any medication(s) including non-prescription medicine? If yes, please explain. ____________	☐	☐
4. Have you ever taken Fen-Phen / Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Do you have or had any of the following:	☐	☐

	YES	NO		YES	NO		YES	NO
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Psychiatric Problems	☐	☐
Other (If yes, please describe)	☐	☐	____________					

	YES	NO
8. Do you have any allergies or allergic reactions? ____________	☐	☐
9. Do you have persistent cough not associated with a known illness? ____________	☐	☐

10. Women only:

	YES	NO
Are you pregnant or think you may pregnant?	☐	☐
Are you nursing?	☐	☐
Are taking oral contraceptives?	☐	☐

	YES	NO
11. Do you need to be premedicated before dental procedures due to medical conditions (i.e. heart murmurs)?	☐	☐

If so, please describe: ____

Patient Dental History

General Dentist's Name ____________________________

Office Phone ________________________ Date of Last Exam ________________________________

	YES	NO		YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☐	8. Do you have frequent headaches?	☐	☐
2. Are your teeth sensitive to hot or cold liquids / foods?	☐	☐	9. Do you clench or grind your teeth?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids / foods?	☐	☐	10. Do you bite your lips or cheeks?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐	11. Have you had any difficult extractions before?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐	12. Have you had any prolonged bleeding following extractions?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐	13. Have you had any orthodontic treatment?	☐	☐
7. Have you ever experienced any of the following in your jaw?					
Clicking	☐	☐			
Pain (joint, ear, side of face)	☐	☐			
Difficulty in opening or closing	☐	☐			
Difficulty in chewing	☐	☐			

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 to pay directly to the dentist or dental group insurance otherwise payable to me. *I understand that my dental insurance carrier may pay less than the actual services rendered on my behalf or my dependents.*

Signature of patient (parent or guardian if minor) ______________________________ Date ____________________

Date	Age	Note / Recommendation	Next Visit

Doctor's Signature ______________________________________ Date ____________________