

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 # _____
SS#/SIN _____
Date _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Email _____ Cell Phone _____
Check appropriate Box: Minor Single Married Divorced Widowed Separated
If Student, name of School/College _____ City _____ State _____ Full Part
Patient or Parent/Guardian's Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____
Whom may we thank for referring you? _____
Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Email _____ Cell Phone _____
Driver's License # _____ Birthdate _____ Financial Institution _____
Employer _____ Work Phone _____ SS# _____
Is this Person Currently a Patient in our Office? Yes No
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
 Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS# _____ 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 _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS# _____ 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 _____
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	YES	NO		YES	NO
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1. Are you under medical treatment now? YES NO
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? YES NO
If yes explain: _____
3. Are you taking and medications(s) including non-prescription medicine? YES NO
If yes, what medication(s) are you taking? _____
4. Have you ever taken Fen-Phen/Redux? YES NO
5. Do you use tobacco? YES NO
6. Do you use controlled substances? YES NO
7. Are you wearing contact lenses? YES NO
8. Do you have or have you had any of the following:

	YES	NO		YES	NO
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>
Fainting / Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy / Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis / Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles / Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
9. Are you allergic to or have you had any reaction to the following:

Local Anesthetics (e.g. Novocain)	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or any other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives	<input type="checkbox"/>	<input type="checkbox"/>
Iodine	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Any Metals (e.g. nickel, mercury, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Latex Rubber	<input type="checkbox"/>	<input type="checkbox"/>
Other (please list) _____		
10. Do you have a persistent cough or throat clearing, not associated with a known illness (lasting more than 3 weeks)? YES NO
11. Women Only:
 - a) Are you pregnant? YES NO
 - b) Are you nursing? YES NO
 - c) Are you taking oral contraceptives? YES NO

Patient Dental History

Name of Previous Dentist and Location _____	Date of Last Exam _____
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	YES	NO		YES	NO
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1. Do your gums bleed while brushing or flossing? YES NO
2. Are your teeth sensitive to hot or cold liquids/foods? YES NO
3. Are your teeth sensitive to sweet or sour liquids/foods? YES NO
4. Do you feel pain to any of your teeth? YES NO
5. Do you have any sores or lumps in or near your mouth? YES NO
6. Have you had any head, neck or jaw injuries? YES NO
7. Have you ever experienced any of the following problems in your jaw?

Clicking	<input type="checkbox"/>	<input type="checkbox"/>
Pain (joint, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have frequent headaches? YES NO
9. Do you clench or grind your teeth? YES NO
10. Do you bite your lips or cheeks frequently? YES NO
11. Have you ever had any difficult extractions in the past? YES NO
12. Have you ever had any prolonged bleeding following extractions? YES NO
13. Have you had any orthodontic treatment? YES NO
14. Do you wear dentures or partials? YES NO
If yes, date of placement _____
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? YES NO
16. Do you like your smile? YES NO

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 payors 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 on my behalf or my dependents.

X _____

Doctor's Comments _____ _____ _____	Signature _____ Date _____
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