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 needs, please fill out this form completely. If you have any questions or need assistance, please ask us, we will be happy to help.
THIS INFORMATION WILL BE CONSIDERED CONFIDENTIAL

Patient Information

Date _____

Soc.Sec. # _____

Name _____ Birthdate _____ Age _____

Address _____

City _____ State _____ Zip _____ Phone _____

☐ E-mail: _____ ☐ Cellphone _____ ☐ Work Phone _____

What is the best way to contact you? Please check above.

Check Appropriate: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer _____ Position _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Work Phone _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____

Relationship to Patient _____

Address _____ Home Phone _____

Driver's license # _____ Birthdate _____

Employer _____ Work Phone _____ SSN# _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Whom May We Thank for Referring You? _____

Insurance Carrier? ☐ Yes ☐ No (If yes, please provide an insurance card)

Name: _____ SSN: _____ DOB: _____

Patient Medical History

Medical Doctor _____ Office phone _____

Date of Last Exam _____

1. Are you under medical treatment now? ☐ Yes ☐ No
2. Have you been hospitalized for any surgical operation or serious illness within the past 5 years? ☐ Yes ☐ No
   If yes, please explain _____
3. Are you taking any medication(s) including non-prescription medicine? ☐ Yes ☐ No
   IF yes, what medication(s) are you taking? _____
4. Do you use smokeless tobacco? / Do you smoke? (Please circle)
5. Do you use controlled substances? ☐ Yes ☐ No
6. Are you wearing contact lenses? ☐ Yes ☐ No
7. Women Only:
   a) Are you pregnant or think you may be pregnant? ☐ Yes ☐ No
   b) Are you nursing? ☐ Yes ☐ No
   c) Are you taking oral contraceptives? ☐ Yes ☐ No
8. Are you allergic to or have you had any reactions to the following?

Local anesthetics (eg novocaine)	☐ Yes	☐ No	Penicillin or any other antibiotics	☐ Yes	☐ No
Sulfa drugs	☐ Yes	☐ No	Barbiturates	☐ Yes	☐ No
Sedatives	☐ Yes	☐ No	Iodine	☐ Yes	☐ No
Aspirin	☐ Yes	☐ No	Any metals (eg. nickel, mercury etc.)	☐ Yes	☐ No
Latex rubber	☐ Yes	☐ No	Other (please list)	☐ Yes	☐ No

_____

Patient Medical History Continued . . .

9. Do you have or have you ever had any of the following?

- ☐ AIDS or HIV Infection
- ☐ Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Artificial Valves
- ☐ Asthma/Hay Fever
- ☐ Blood Diseases
- ☐ Breast Implants
- ☐ Cancer / Chemo Therapy? If so, when? What type of cancer?

  _____
- ☐ Chest Pains
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting Spells
- ☐ Glaucoma/Cataracts
- ☐ Head Aches
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hearing Loss
- ☐ Hepatitis/Liver Disease
- ☐ HPV (Human Papaloma Virus) positive?
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Nose Bleeds
- ☐ Numbness
- ☐ Psychiatric Treatment
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Rheumatism/Arthritis
- ☐ Seizures
- ☐ Shingles
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Stomach Ulcers
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Venereal Disease

Patient Dental History

1.	Do your gums bleed while brushing or flossing?	☐ Yes	☐ No
2.	Are your teeth sensitive to hot or cold?	☐ Yes	☐ No
3.	Are your teeth sensitive to sweet or sour?	☐ Yes	☐ No
4.	Do you feel pain to any of your teeth?	☐ Yes	☐ No
5.	Do you have 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 experienced any of the following problems in your jaw?		
	Clicking	☐ Yes	☐ No
	Pain (joint, ear, side of face)	☐ Yes	☐ No
	Difficulty in opening or closing	☐ Yes	☐ No
	Difficulty in chewing	☐ Yes	☐ No
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.	Are you a mouth breather?	☐ Yes	☐ No
12.	Have you ever had any unfavorable reaction from a local anesthetic?	☐ Yes	☐ No
13.	Have you ever had any prolonged bleeding following extractions?	☐ Yes	☐ No
14.	Have you had any orthodontic treatment?	☐ Yes	☐ No
15.	Do you wear dentures or partials?	☐ Yes	☐ No

If yes, date of placement _____

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 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.

_____ _____

Signature of Patient (or parent if minor) Date