Thank You for Selecting Our Dental Team

To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name ______________________ Date ______________
Soc. Sec. # ______________ 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 Time ☐ Part Time
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 ______________
Birthdate ______________
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 is due when services are rendered.
☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ American Express ☐ I wish to discuss outside financing options.

Insurance Information

Name of Insured ______________________ Relationship to Patient ______________
Birthdate ______________ Social Security # ______________ Date Employed ______________
Name of Employer ______________ Union or Local # ______________ Work Phone ______________
Employer Address ______________ 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 ______________ Social Security # ______________ Date Employed ______________
Name of Employer ______________ Union or Local # ______________ Work Phone ______________
Employer Address ______________ 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? ______________

Over Please

Patient Medical History

Physician ______________________ 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 within the last 5 years?	☐	☐
If yes, please explain ______________________		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? ______________________		
4. Have you ever taken Phen-Fen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐

9. Are you allergic to or have you had any reactions to the following:	Yes	No
Local Anesthetics (e.g. novocaine)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates, Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other ______________________	☐	☐
10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
11. Women Only:		
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

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

	Yes	No
Rheumatic Heart Disease or Rheumatic Fever	☐	☐
Scarlet fever	☐	☐
Heart defect or heart murmur	☐	☐
Heart trouble, heart attack, or angina	☐	☐
Chest Pain	☐	☐
Shortness of breath	☐	☐
Pacemaker	☐	☐
Heart surgery	☐	☐
High/low blood pressure	☐	☐
Congenital heart problem	☐	☐
Swelling of feet, ankles, hands	☐	☐
Hepatitis, jaundice or liver disease	☐	☐
Stroke	☐	☐
Sinus trouble	☐	☐

	Yes	No
Lung or breathing problems	☐	☐
Asthma or hay fever	☐	☐
Hives or skin rash	☐	☐
Fainting or dizzy spells	☐	☐
Diabetes	☐	☐
AIDS or HIV infection	☐	☐
Thyroid problems	☐	☐
Allergies	☐	☐
Arthritis or rheumatism	☐	☐
Joint replacement or implant	☐	☐
Stomach ulcer	☐	☐
Kidney trouble	☐	☐
Tuberculosis	☐	☐
Persistent cough	☐	☐
Cough that produces blood	☐	☐

	Yes	No
Chemotherapy (cancer, leukemia)	☐	☐
Sexually transmitted diseases	☐	☐
Epilepsy or seizures	☐	☐
Anemia	☐	☐
Glaucoma	☐	☐
Nervousness	☐	☐
Tonsillitis	☐	☐
Tumors	☐	☐
Mental health care	☐	☐
Back problems	☐	☐
Chemical dependency	☐	☐
Mitral valve prolapse	☐	☐
Cortisone treatment	☐	☐
Cold sores / fever blisters	☐	☐
Hypoglycemia	☐	☐
Eating disorders	☐	☐

Patient Dental History

Name of Previous Dentist ______________________ Date of Last Exam ____________

Previous Dentist's Location ______________________ Date of Last Cleaning ____________

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement ____________		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐
17. Would you like your teeth to be whiter?	☐	☐

If you could change anything about your smile, what would you change?

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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 agree to be responsible for payment of all services rendered on my behalf or my dependents.

X ____

Signature of patient (or parent / guardian if minor)

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