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*_____*Zip*_____

*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#/SIN*_____

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#/SIN*_____*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? IF YES, COMPLETE THE FOLLOWING:

*Name of Insured*_____*Relationship to Patient*_____

*Birthdate*_____*SS#/SIN*_____*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*_____

Patient Medical History

*Physician*_____ *Office Phone*_____ *Date of Last Visit*_____

	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 Fen-Phen/Redux?.....	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?.....	☐	☐
6. Have you taken Viagra, Revati, Cialis or Levitra in the last 24 hours?.....	☐	☐
7. Do you use tobacco?.....	☐	☐
8. Do you use controlled substances?.....	☐	☐
9. Do you have or have you had any of the following?		

	Yes	No
10. Are you wearing contact lenses?.....	☐	☐
11. Are you allergic to or have you had any reactions to the following:		
Penicillin or any other Antibiotics.....	☐	☐
Sulfa Drugs.....	☐	☐
Barbiturates.....	☐	☐
Sedatives.....	☐	☐
Iodine.....	☐	☐
Aspirin.....	☐	☐
Any Metals (E.g. nickel, mercury, etc.).....	☐	☐
Latex Rubber.....	☐	☐
Other (please list)_____	☐	☐
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?.....	☐	☐
c) Are you taking oral contraceptives?.....	☐	☐

Over Please

	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.....	☐	☐	Other_____	☐	☐

Patient Dental History

*Name of Previous Dentist and Location*_____ *Date of Last Visit*_____

	Yes	No
1. Do your gums bleed while brushing or flossing?.....	☐	☐
2. Are your teeth sensitive to hot or cold liquids/food?.....	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/food?.....	☐	☐
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 ever 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?.....	☐	☐

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 that the actual bills for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

*X*_____

Signature of patient (or parent/guardian if minor) *Date*

*Doctor's Comments*_____

_____

_____*Signature*_____*Date*_____