Welcome

Patient Information (Confidential)

Name ______________________________ Birthdate___/___/___ Home phone__________
MailingAddress__________________________City______________State__________
Zip ____________SS#_____-_____-_____ Cell phone # ____________________
Circle one: Minor Single Married Divorced Widowed Separated
Name of Employer______________________________ Work#______________
Person to contact in case of emergency ______________________Phone #__________
Whom may we thank for referring you? ______________________________
If Student, name of school / College ________________________
Full-time or Part-time

Responsible Party (fill out if patient is minor or different from insured)

Name of person responsible for this account______________ Relationship ________
Address ______________________________________ Phone # __________
Employer ______________________ Work # ____________ Cell #__________
Are you currently a patient in our office? (Circle one) Yes or No

Insurance Information

***For your convenience, we offer the following methods of payment: cash, Check, Visa, American Express, Master Card, and Discover. We file insurance as a courtesy therefore; we ask that you pay your estimated part at the time of service.**

Name of insured______________________________Relationship__________
Birthdate___/___/___SS# _____-_____-_____
Name of Employer ____________________________
Insurance Company ____________________________ Group #______________
ID # ____________________ Dental customer Service # __________________
Dental Claims Address____

Patient Medical History

Date of Last exam________________
Are you under any treatment now______________
Have you been hospitalized for any major surgeries in the last five years? __________
If yes, please explain ____
Medical Physician __________________________ Office #______________
Are you currently taking any medications(s) including non-prescriptions? _________
If yes, please list all ____
Do you use Tobacco? ______________ Do You use Controlled Substances? __________

Please check any of the following that apply to you......

_High Blood Pressure
_Low Blood Pressure
_Fainting / Seizures
_Diabetes
_Thyroid Problems
_Cardiac Pacemaker
_Frequently Tired
_Joint Replacement / implant
_Arthritis
_Chest Pains
_Hay Fever / Allergies
_Glaucoma
_Mitral Valve Prolapse
_Heart Attack
_Swollen Ankles
_Epilepsy / Convulsions
_Kidney Diseases
_Heart Disease
_Heart Murmur
_Anemia
_Hepatitis / Jaundice
_Sexually Transmitted Disease
_Easily Winded
_Tuberculosis
_Recent Weight Loss
_Other ____________________
_Rheumatic Fever
_Asthma
_Leukemia
_AIDS or HIV
_Heart Trouble
_Angina
_Emphysema
_Cancer
_Stomach Troubles / Ulcers
_Stroke
_Radiation Therapy
_Liver Disease

Continued on back...

Are you allergic too or have ad any reactions to the following:

**Local anesthics (e.g. Novacaine)*	*yes or no*
**Iodine*	*yes or no*
**Aspirin*	*yes or no*
**Any metals (e.g. nickel, mercury..)*	*yes or no*
**Latex Rubber*	*yes or no*
**Penicillin*	*yes or no*
**Motrin*	*yes or no*

**Others (please list)* ____

*** Women Only**

Are you pregnant or think you may be pregnant?	*yes or no*
Are you nursing	*yes or no*
Are you taking oral contraceptives?	*yes or no*

Patient Dental History

Check all that apply to you…

Do your gums bleed while brushing or flossing?	*Yes or no*
Are your teeth sensitive to hot or cold liquids/food?	*Yes or no*
Are your teeth sensitive to sweet or sour foods/liquids?	*Yes or no*
Do you feel pain to any of your teeth?	*Yes or no*
Do you have any sores or lumps in or around your mouth?	*Yes or no*
Have you had any head, neck, or jaw injuries?	*Yes or no*

Have you ever experienced any of the following problems?

- *a. Clinching*
- *b. Pain (joint, ear, side of face)*
- *c. Difficulty in opening or closing*
- *d. Difficulty in chewing*
- *e. Frequent headaches*
- *f. Biting your lips or cheeks*
- *g. Difficulty with extractions*

Have you had any orthodontic treatment?	*Yes or no*
Do you wear dentures or partials?	*Yes or no*

If so, date of placement ______________________

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Authorization

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care, therefore; please make sure the above questions are answered honestly and to the best of your knowledge. I understand that providing false information I can be misdiagnosed and it could jeopardize 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 company to pay dental benefits to my provider. I also understand that all insurance is an estimate and my insurance carrier may pay less than the actual services. I understand and agree to be responsible for payment of all services when rendered on my behalf and/or my dependents.

Sign____Date__/__/__