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 in ink. If you have any questions or need assistance, please feel free to ask - we'll be happy to help.

We will earn the right to your referral!

Today's Date: _____/_____/_____

Name: _____ Mr. ❑ Mrs. ❑ Ms. ❑
Last First Middle Initial

I prefer to be called: _____ Male ❑ Female ❑

Birthdate: _____/_____/_____ Age _____

SS# _____ - _____ - _____

Home Address _____

Apt/Condo # _____ City _____

State _____ Zip Code _____

Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑

Home Phone: (____) _____ - _____

Work Phone: (____) _____ - _____

Cellular: (____) _____ - _____

Pager: (____) _____ - _____

e-mail Address: _____

Whom may we thank for inviting you to our practice? _____

Other family members seen by us: _____

Employer: _____

Employer's Address: _____

City _____ State ____ Zip Code _____

Length of employment: _____ Occupation: _____

Person Responsible for Account: Same as above ❑ Other: ❑

Name: _____

Billing Address _____

City _____

Address _____

Zip Code _____

Employer _____

Employer Phone: (____) _____ - _____

Home Phone: (____) _____ - _____

Relationship to Patient: _____

SS# _____ - _____ - _____

In the event of an emergency, who should we contact?

His/Her Name: _____

Relationship: _____

Home Phone: (____) _____ - _____

Other #: (____) _____ - _____

Primary Insurance

Dental Coverage? Yes ❑ No ❑

Insurnace Company Name: _____

Address: _____

_____

Phone: (____) _____ - _____

Group Number (Plan, Local or Policy #):

_____

Policy Owner's Name: _____

Relation: _____

Policy Owner's Birthdate: _____ / _____ / _____

SS# _____ - _____ - _____

Policy Owner's Employer: _____

_____

Secondary Insurance

Dental Coverage? Yes ❑ No ❑

Insurance Company Name: _____

Address: _____

_____

Phone: (____) _____ - _____

Group Number (Plan, Local or Policy #):

_____

Policy Owner's Name: _____

Relation: _____

Policy Owner's Birthdate: _____ / _____ / _____

SS# _____ - _____ - _____

Policy Owner's Employer: _____

_____

General & Insurance Info.

Do you have or have you experienced the following diseases or medical problems?

	Y	N		Y	N
Artificial Bones/Joints/Implants	☐	☐	Angina/Chest Pain	☐	☐
Organ Transplant	☐	☐	Rheumatic Fever	☐	☐
Heart Defect/Heart Murmur	☐	☐	Sinus Trouble	☐	☐
Artificial Valves/Pacemaker	☐	☐	Thyroid Problems	☐	☐
Heart Surgery/Bypass Surgery	☐	☐	Chicken Pox/Shingles	☐	☐
Heart Attack/Stroke	☐	☐	Fainting Spells	☐	☐
HIV+/AIDS	☐	☐	Fever Blisters/Cold Sores	☐	☐
Cancer	☐	☐	Sexually Transmitted Disease (STD)	☐	☐
Chemotherapy/Radiation	☐	☐	Herpes/Canker Sores	☐	☐
Frequent Headaches/Migraines	☐	☐	Glaucoma/Poor Vision	☐	☐
Epilepsy/Seizures	☐	☐	Hay Fever/Seasonal Allergies	☐	☐
Psychiatric/Mental Illness	☐	☐	Hepatitis/Jaundice	☐	☐
Alcohol/Drug Abuse	☐	☐	Liver Disease	☐	☐
Anemia/Sickle Cell Disease	☐	☐	Kidney Problems	☐	☐
Bleeding Problems/Hemophilia	☐	☐	Hives/Skin Rash	☐	☐
Arthritis/Rheumatism	☐	☐	High/Low Blood Pressure	☐	☐
Asthma/Difficulty Breathing	☐	☐	High Cholesterol	☐	☐
Persistent Cough Emphysema	☐	☐	Hearing Aid/Hearing Loss	☐	☐
Shortness of Breath/Easily Winded	☐	☐	Swollen Ankles	☐	☐
Diabetes	☐	☐	Tuberculosis	☐	☐
Colitis/Ulcer/Stomach Trouble	☐	☐	Tonsillitis/Tonsils Removed	☐	☐

Are you allergic or have you had a bad reaction to any of the following?

Latex/Rubber Products	Y ☐	N ☐	Aspirin/Ibuprofen	Y ☐	N ☐
Penicillin or Other Antibiotics	Y ☐	N ☐	Barbiturates/Sedatives	Y ☐	N ☐
Codeine	Y ☐	N ☐	Jewelry/Other Metals	Y ☐	N ☐
Dental Local Anesthetics	Y ☐	N ☐	Sulfa Drugs	Y ☐	N ☐

Please list additional drugs that cause allergic reactions: _____

_____

Are you taking any of the following?:

Blood Pressure Medication	Y ☐	N ☐	Bisphosphonates	Y ☐	N ☐
			Blood Thinners	Y ☐	N ☐
Antibiotics	Y ☐	N ☐	Aspirin/Ibuprofen	Y ☐	N ☐
Digitalis/Heart Medicine	Y ☐	N ☐	Antihistamines	Y ☐	N ☐
Insulin/Diabetes Drugs	Y ☐	N ☐	Thyroid Medicine	Y ☐	N ☐
Antidepressants	Y ☐	N ☐	Acetaminophen/Tylenol	Y ☐	N ☐
Steroids/Cortisone	Y ☐	N ☐	Nitroglycerin	Y ☐	N ☐

Are you taking any prescription/over-the-counter drugs not listed above?

If yes, please list each one and the dosage _____

_____

Do you have a personal physician? Y ☐ N ☐

If yes, please include: Physician's Name: _____

Telephone # (_____) _____ - _____

How do you rate your current physical health? Excellent ☐ Good ☐ Fair ☐ Poor ☐

For Women Only:

Are you pregnant or planning pregnancy?	Y ☐	N ☐
Are you breast feeding?	Y ☐	N ☐
Are you taking birth control pills?	Y ☐	N ☐
Do you take hormone replacement therapy?	Y ☐	N ☐

If so, what is the name & dosage of the medication? _____

Are you currently under the care of a physician for any illness? Y❑ N❑
If yes, please explain: _____

_____

Do you smoke or use tobacco in any other form? Y❑ N❑
Do you use alcohol? Y❑ N❑
Do you use recreational drugs? Y❑ N❑
Which type(s)? _____
Do you wear contact lenses? Y❑ N❑
Do you have any disease, condition or problem not listed that you think I should know about?

_____

_____

Have you been hospitalized for any surgical operation or serious illness within the past 5 years? Y❑ N❑
If yes, please explain: _____

Do you have or have you ever had a history of photosensitive reactions or using photosensitizing drugs? Y❑ N❑
If yes, please explain: _____

Do you take any herbal/holistic medications: Y❑ N❑
If yes, please list: _____

Are you dieting and/or taking any weight loss medications? Y❑ N❑
Do you have or did you ever have any eating/nutrition disorder? Y❑ N❑
Do you have a restrictive diet? Y❑ N❑

Why have you come to the dentist today?

_____

When was your last dental examination and professional cleaning_____/_____/_____

Are you currently in pain? Y❑ N❑

Have you experienced any problems associated with previous dental work? Y❑ N❑

Is there anything about having dental treatment that bothers you? Y❑ N❑
(If yes, please explain)_____

Have you ever been instructed in the prevention of decay? Y❑ N❑
Have you ever been instructed in caring for your gums? Y❑ N❑
Do your gums bleed while brushing or flossing? Y❑ N❑
How often do you brush?_____
How often do you floss your teeth?_____
Are your teeth sensitive to hot, cold, sweet or sour foods/liquids? Y❑ N❑
Do you experience any breath malodor/halitosis? Y❑ N❑

Do you now or have you ever experienced pain/discomfort in your jaw joint/TMJ? Y❑ N❑

Have you had any head, neck or jaw injuries?
Are you aware of clenching or grinding your teeth while awake or sleeping? Y❑ N❑
Do you have any lumps or sores in or near your mouth? Y❑ N❑
Do you bite your cheeks frequently? Y❑ N❑

Have you ever had the following:
1. Orthodontic treatment (braces) Y❑ N❑
2. Oral Surgery/tooth extraction Y❑ N❑
3. Gum Disease/Gum Treatment Y❑ N❑
4. Bite Appliance/Night guard Y❑ N❑

Do you participate in sports or activities that have the potential to damage your teeth or jaw?
If yes, please list: _____

Are you happy with the appearance of your teeth/gums/smile? Y ❑ N ❑

Would you like to discuss enhancing the appearance of your smile? Y ❑ N ❑

What don't you like about your smile? _____

Would you like to discuss how to make your teeth brighter? Y ❑ N ❑

On a scall of 1 to 10, where does your health/oral health rate in comparison with all of your other priorities?

O1 O2 O3 O4 O5 O6 O7 O8 O9 O10

Lowest Highest

Why did you leave your last dentist?

_____

_____

What are your expectations of us?

_____

_____

I affirm that the information I have given today is correct to the best of my knowledge. I understand that the information will be held in the strictest confidence and it is my responsibility to inform this office of any changes.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me, to third party payors and/or other practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand that I am responsible for payment of services rendered and agree to pay any copayments and deductible that my insurance does not cover.

For your convenience, we offer the following payment options:

Please check the option which you prefer:

❑ Cash

❑ Personal Check

❑ Credit Card

❑ Visa ❑ MasterCard ❑ Discover ❑ American Express

Signature: _____

Date: _____/_____/_____

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