

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 Information (CONFIDENTIAL)

Name	Birthdate
Address	City
State/Prov.	Zip/P.C.
Home Phone	
Email	Cell Phone
Date	SS#/SIN (optional)
Patient's Sex ☐ F ☐ M	
Do you prefer to receive calls at your: ☐ Home ☐ Work ☐ Cell Phone	
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated	
If Student, Name of School/College	City
State/Prov.	
Student status ☐ Full Time ☐ Part Time	
Patient or Parent/Guardian's Employer	Work Phone
Business Address	City
State/Prov.	Zip/P.C.
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 (optional)	
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 ☐ Credit Card: MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured			Relationship to Patient	
Birthdate	SS#/SIN (optional)	Date Employed		
Name of Employer			Union or Local #	
Work Phone	Address of Employer			
City	State/Prov.	Zip/P.C.		
Insurance Company			Group #	
Policy/ID #	Ins. Co. Address			
City	State/Prov.	Zip/P.C.		
How much is your deductible?	How much have you used?	Max. annual benefit		

Do you have any additional insurance? Yes ☐ No ☐

Additional insurance (if yes, complete the following)

Name of Insured			Relationship to Patient	
Birthdate	SS#/SIN (optional)	Date Employed		
Name of Employer			Union or Local #	
Work Phone	Address of Employer			
City	State/Prov.	Zip/P.C.		
Insurance Company			Group #	
Policy/ID #	Ins. Co. Address			
City	State/Prov.	Zip/P.C.		
How much is your deductible?	How much have you used?	Max. annual benefit		

Patient Medical History

Physician			Office Phone	
Date of Last Exam				
1. Are you under medical treatment now?				Yes ☐ No ☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 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? _____

- | | Yes | No |
|---|--------------------------|--------------------------|
| 4. Have you ever taken Fen-Phen/Redux? | ☐ | ☐ |
| 5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? | ☐ | ☐ |
| 6. Have you taken Viagra, Revatio, 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 | 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 (please describe) _____

- | Yes | No |
|---|--------------------------|
| ☐ | ☐ |
| 10. Are you wearing contact lenses? | |

11. Are you allergic to or have you had any reactions to the following?

- | Yes | No |
|---|--------------------------|
| ☐ | ☐ |
| Local Anesthetics (e.g. Novocain) | |
| ☐ | ☐ |
| Penicillin or any other Antibiotics | |
| ☐ | ☐ |
| Sulfa Drugs | |
| ☐ | ☐ |
| Barbiturates | |
| ☐ | ☐ |
| Sedatives | |
| ☐ | ☐ |
| Iodine | |
| ☐ | ☐ |
| Aspirin | |
| ☐ | ☐ |
| Any Metals (e.g. nickel, mercury, etc.) | |
| ☐ | ☐ |
| Latex Rubber | |
| ☐ | ☐ |

Other _____

- | Yes | No |
|--|--------------------------|
| ☐ | ☐ |
| 12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? | |

13. Women Only:

- | Yes | No |
|---|--------------------------|
| ☐ | ☐ |
| a) Are you pregnant or think you may be pregnant? | |
| ☐ | ☐ |
| b) Are you nursing? | |
| ☐ | ☐ |
| c) Are you taking oral contraceptives? | |
| ☐ | ☐ |

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

- | | 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?

- | | Yes | No |
|---|--------------------------|--------------------------|
| Clicking | ☐ | ☐ |
| Pain (joint, ear, side of face) | ☐ | ☐ |
| Difficulty in opening or closing | ☐ | ☐ |
| Difficulty in chewing | ☐ | ☐ |
| 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 _____

- | | Yes | No |
|---|--------------------------|--------------------------|
| 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

Payment is due in full at the time of treatment unless prior arrangements have been approved. This office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company. I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

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