PATIENT INFORMATION

Thank you for selecting us!
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 assist you.

What is the reason for your visit today? _____

_____

Date _____
Soc. Sec. No. _____

Name: _____ Date of Birth _____ Age __
Address _____ City _____ State _____ Zip _____
Home phone _____ Cell phone _____ Work phone _____
E-Mail _____
Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Whom May We Thank for Referring you? _____
Person to Contact in Case of Emergency _____ Phone _____

INSURANCE INFORMATION

Relationship
Name of Insured _____ to Patient _____
Date of Birth _____ Soc. Sec. No. _____
Name of Employer _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group No. _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Relationship
Name of Insured _____ to Patient _____
Date of Birth _____ Soc. Sec. No. _____
Name of Employer _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____
Group No. _____ ID# _____

Over Please

PATIENT MEDICAL HISTORY

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any		
7. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (eg. Novocaine)	☐	☐

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. Do you use Tobacco? ☐ ☐
5. Do you use controlled substances? ☐ ☐
6. Are you wearing Contact Lenses? ☐ ☐

Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (Please list)	☐	☐

8. **Women Only:**
a) Are you pregnant or think you may be pregnant? ☐ ☐
b) Are you nursing? ☐ ☐
c) Are you taking oral contraceptives? ☐ ☐

8. 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 Repl. or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
Aids or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapsed	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐	Other _____		

PATIENT DENTAL HISTORY

a. When was your last dental visit? _____

b. Why did you leave your last dentist? _____

c. What did you like most and least about any Dentist you ever gone to in your life? _____
_____
_____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquid/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquid/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 problems in your jaw? (explain)	☐	☐
_____		
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 time 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 than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____
Signature of patient (or parent if minor)