

Patient Information

(CONFIDENTIAL)

SS #/SIN _____
Date _____
Patient's Sex F M
Home Phone _____
State _____ Zip _____
Cell Phone _____

Name _____ Birthdate _____
Address _____ City _____
Email _____ Cell Phone _____

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 _____ Time Time
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

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? Yes No 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 _____
How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

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

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? _____
4. Have you ever taken Fen-Phen/Redux? Yes No
5. Do you use tobacco? Yes No
6. Do you use controlled substances? Yes No
7. Are you wearing contact lenses? Yes No

9. Are you allergic to or have you had any reactions to the following?
- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| Local Anesthetics (e.g. Novocaine)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin or any other Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Sedatives..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Iodine | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Any Metals (e.g. nickel, mercury, etc.)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Latex Rubber..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Other (please list)..... | <input type="checkbox"/> | <input type="checkbox"/> |
10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks). Yes No
11. Are you taking any bisphosphonate medications? Yes No
12. a) Are you pregnant or think you may be pregnant? Yes No
b) Are you nursing? Yes No
c) Are you taking oral contraceptives? Yes No

8. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles.....	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever / Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>
Fainting / Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy / Convulsions.....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble.....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis / Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection.....	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem.....	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles / Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>

Patient Dental History

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

1. Do your gums bleed while brushing or flossing? Yes No
2. Are your teeth sensitive to hot or cold liquids/foods? Yes No
3. Are your teeth sensitive to sweet or sour liquids/foods? Yes No
4. Do you feel pain to any of your teeth? Yes No
5. Do you have any sores or lumps in or near your mouth? Yes No
6. Have you had any head, neck or jaw injuries? Yes No
7. Have you experienced any of the following problems in your jaw?
- | | | |
|---------------------------------------|--------------------------|--------------------------|
| Clicking | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain (joint, ear, side of face) | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in opening or closing..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in chewing | <input type="checkbox"/> | <input type="checkbox"/> |

8. Do you have frequent headaches? Yes No
9. Do you clench or grind your teeth? Yes No
10. Do you bite your lips or cheeks frequently? Yes No
11. Have you ever had any difficult extractions? in the past? Yes No
12. Have you ever had any prolonged bleeding following extractions? Yes No
13. Have you had any orthodontic treatment? Yes No
14. Do you wear dentures or partials? Yes No
If yes, date of placement _____
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? Yes No
16. Do you like your smile? Yes No