Thank You for Selecting Our Dental Team

To help us meet all your healthcare needs, please fill out the front and back of this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name _____ Patient Email _____

Soc. Sec. # _____ Birthdate _____ Date _____

Home Phone _____

Cell Phone _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School / College _____ City _____ State _____ ☐ Full Time ☐ Part Time

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent'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 _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS# _____

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 ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Dental History

1. Reason for visit: _____
2. When was your last dental visit? _____
3. How often do you brush your teeth? _____
4. What texture brush do you use? ☐ Soft ☐ Medium ☐ Hard

	YES	NO
5. Do your gums bleed while brushing?	☐	☐
6. Do your gums bleed when flossing?	☐	☐
7. Do you feel pain to any of your teeth when brushing or flossing them?	☐	☐
8. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids?	☐	☐
9. Have you noticed any loosening of your teeth?	☐	☐
10. Does food tend to become caught between your teeth?	☐	☐
11. Do you have any sores or lumps in or near your mouth?	☐	☐
12. Have you ever experienced any of the following problems in your jaw?	☐	☐
a. Clicking?	☐	☐
b. Pain (joint, ear, side of face)?	☐	☐
c. Difficulty in opening or closing?	☐	☐
d. Difficulty in chewing?	☐	☐
13. Have you had any head, neck, or jaw injuries?	☐	☐
14. Have you ever fainted?	☐	☐
15. Do you have ringing in your ears (Tinnitis)?	☐	☐
16. Do you have frequent headaches or migraines?	☐	☐
17. Do you clench or grind your teeth while awake or asleep?	☐	☐
18. Do you bite your lips or cheeks frequently?	☐	☐
19. Have you ever had:		
a. Orthodontic treatment (braces)?	☐	☐
b. Oral surgery?	☐	☐
c. Gum treatment?	☐	☐
d. Your teeth ground or the bite adjusted?	☐	☐
e. Worn a bite plane or other appliance?	☐	☐
20. Are you satisfied with the appearance of your teeth?	☐	☐
21. Have you ever had an upsetting experience in the dental office?	☐	☐
22. Is there anything about having dental treatment that bothers you?	☐	☐

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

	YES	NO
1. Are you in good health?	☐	☐
2. Have there been any changes in your general health within the past year?	☐	☐
3. Date of your last physical exam: _____		
4. Physician's name _____ Address _____ Phone No. _____		
5. Are you now under the care of a physician?	☐	☐
6. Have you ever been hospitalized for any surgical operation or serious illness? Please explain. _____	☐	☐
7. Are you taking any medicine(s) including non-prescription medicine? If yes, what medicine(s) are you taking? _____	☐	☐
8. Have you ever taken appetite suppressants - Fen-Phen (Fenluramine & Phentemine or Dexfenfluramine or Fenflurameine)?	☐	☐
9. Have you had any abnormal bleeding?	☐	☐
10. Do you bruise easily?	☐	☐
11. Have you ever required a blood transfusion?	☐	☐
12. Have you had a recent weight loss?	☐	☐
13. Do you use tobacco?	☐	☐
14. Do you use alcohol?	☐	☐
15. Do you use controlled substances?	☐	☐
16. Do you have any disease, condition or problem not listed above that you think I should know about?	☐	☐

Women Only:

1. Are you pregnant or think you may be pregnant?	☐	☐
2. Are you nursing?	☐	☐
3. Are you taking birth control pills?	☐	☐

	YES	NO
Are you allergic to or have you had reactions to:		
1. Local anesthetics like novocaine?	☐	☐
2. Penicillin or other antibiotics?	☐	☐
3. Sulfa drugs?	☐	☐
4. Barbiturates, sedatives or sleeping pills?	☐	☐
5. Aspirin?	☐	☐
6. Iodine?	☐	☐
7. Latex gloves?	☐	☐
8. Other? _____		
Do you have or have you ever had the following:		
1. Rheumatic heart disease or rheumatic fever?	☐	☐
2. Scarlet fever?	☐	☐
3. Heart defect or heart murmur?	☐	☐
4. Heart trouble, heart attack, or angina?	☐	☐
a. Do you have pain in your chest upon exertion?	☐	☐
b. Are you ever short of breath after mild exercise?	☐	☐
c. Do your ankles swell?	☐	☐
d. Do you get short of breath when you lie down?	☐	☐
e. Do you require extra pillows when you sleep?	☐	☐
5. Pacemaker?	☐	☐
6. Heart surgery?	☐	☐
7. High blood pressure?	☐	☐
8. Low blood pressure?	☐	☐
9. Hepatitis, jaundice or liver disease?	☐	☐
10. Stroke?	☐	☐
11. Sinus trouble?	☐	☐
12. Lung or breathing problems?	☐	☐
13. Asthma or hay fever?	☐	☐
14. Hives or skin rash?	☐	☐
15. Fainting spells or seizures?	☐	☐
16. Diabetes?	☐	☐
17. AIDS or HIV infection?	☐	☐
18. Thyroid problems?	☐	☐
19. Allergies?	☐	☐
20. Arthritis or rheumatism?	☐	☐
21. Joint replacement or implant?	☐	☐
22. Stomach ulcer?	☐	☐
23. Kidney trouble?	☐	☐
24. Tuberculosis?	☐	☐
25. Persistent cough?	☐	☐
26. Cough that produces blood?	☐	☐
27. Cancer?	☐	☐
28. Sexually transmitted disease?	☐	☐
29. Epilepsy?	☐	☐
30. Anemia?	☐	☐
31. Leukemia?	☐	☐
32. Glaucoma?	☐	☐
33. Radiation Therapy?	☐	☐
34. Chemotherapy?	☐	☐
35. Sleep Apnea	☐	☐

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Consent:

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1½% finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.
6. I authorize the use of my social security number to file my dental claim.

Patient _____ Date _____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN

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