

We are complimented that you have selected us to provide dental care for you and your family.  
Whom may we thank for referring you to our office? \_\_\_\_\_

### Patient Information

Patient's Name	_____	_____	_____
	Last	First	Middle
Address	_____	_____	_____
	Street	City	State Zip
Home Phone ( )	_____	Social Security#	_____ - _____ - _____ Drivers License # _____
Birthday	____/____/____	If patient is a minor, give parent's/guardian's name _____	
Name of nearest relative not living with you	_____	Relationship _____	
Complete Address	_____	Phone ( ) _____	
Emergency Contact	_____	Phone ( ) _____	

### Responsible Party Information

Name	_____	_____	_____	Marital Status	_____
	Last	First	Middle		
Address	_____	_____	_____	State	Zip
	Street		City		
E-mail Address	_____	Home Phone ( )	_____	Work Phone ( )	_____
Social Security#	_____	Birthdate	____/____/____	Relationship to Patient _____	
Employer	_____				
Employer Address	_____				
Spouse's Name	_____				
Spouse's Employer	_____	Work Phone ( )	_____		
Spouse's Social Security #	_____ - _____ - _____	Birthdate	____/____/____		

### Insurance Information

Insured's Name	_____	Insured's Soc. Sec. #	_____ - _____ - _____
Insurance Company	_____	Group No.	_____
Insurance Company Address	_____	Phone No. ( )	_____
<b>Do you have dual coverage? Yes ___ No ___</b> If yes: Please complete the following secondary insurance information.			
Insured's Name	_____	Insured's Soc. Sec. #	_____ - _____ - _____
Insurance Company	_____	Group No.	_____
Insurance Company Address	_____	Phone No. ( )	_____
Insured's Employer	_____	Phone No. ( )	_____

## Dental Information

Do your gums bleed occasionally when you brush? Yes\_\_ No \_\_

Are your teeth sensitive to heat or cold? Yes\_\_ No \_\_

Are your teeth sensitive to pressure? Yes \_\_ No\_\_

Are your teeth sensitive to sweets? Yes \_\_ No \_\_

Do you grind or clench your teeth? Yes \_\_ No \_\_

Do you have any fear of dental work? Yes \_\_ No \_\_

Date of last dental examination \_\_\_\_\_

Date of last Full Mouth X-rays \_\_\_\_\_

What was done at that time?

\_\_\_\_\_

\_\_\_\_\_

How would you describe your current dental problem? \_\_\_\_\_

\_\_\_\_\_

How do you feel about the appearance of your teeth? \_\_\_\_\_

\_\_\_\_\_

What is your main complaint? \_\_\_\_\_

\_\_\_\_\_

# Health History Form



American Dental Association  
www.ada.org

E-mail: \_\_\_\_\_ Today's Date: \_\_\_\_\_

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: \_\_\_\_\_ Home Phone: *Include area code* \_\_\_\_\_ Business/Cell Phone: *Include area code* \_\_\_\_\_  
Last First Middle  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Mailing address  
 Occupation: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Sex: M F  
 SS# or Patient ID: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
( ) ( ) include area codes

If you are completing this form for another person, what is your relationship to that person?

Your Name \_\_\_\_\_ Relationship \_\_\_\_\_  
**Do you have any of the following diseases or problems:** (Check DK if you Don't Know the answer to the question) Yes No DK

Active Tuberculosis .....     
 Persistent cough greater than a 3 week duration .....     
 Cough that produces blood.....     
 Been exposed to anyone with tuberculosis .....

**If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.**

## Dental Information For the following questions, please mark (X) your responses to the following questions.

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw? ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does food or floss catch between your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatment? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam: What was done at that time?			
Do you drink bottled or filtered water? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of last dental x-rays:			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY							
Are you currently experiencing dental pain or discomfort? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
What is the reason for your dental visit today?							

How do you feel about your smile?

## Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK		Yes	No	DK
Are you now under the care of a physician? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician Name: _____ Phone: <i>Include area code</i> _____				If yes, what was the illness or problem?			
Address/City/State/Zip: _____				Are you taking or have you recently taken any prescription or over the counter medicine(s)? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you in good health? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:			
Has there been any change in your general health within the past year? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
If yes, what condition is being treated?				_____			
Date of last physical exam:				_____			

**Medical Information** Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

**(Check DK if you Don't Know the answer to the question)**      **Yes No DK**      **Yes No DK**

Do you wear contact lenses? .....         Do you use controlled substances (drugs)? .....

Are you taking, or have you taken, any diet drugs such as  
Pondimin (fenfluramine), Redux (dexphenfluramine) or  
phen-fen (fenfluramine-phentermine combination)? .....         Do you use tobacco (smoking, snuff, chew, bidis)? .....

Are you taking or scheduled to begin taking either of the  
medications, alendronate (Fosamax®) or risedronate (Actonel®)  
for osteoporosis or Paget's disease? .....         If so, how interested are you in stopping?  
(Circle one) VERY / SOMEWHAT / NOT INTERESTED

Since 2001, were you treated or are you presently scheduled  
to begin treatment with the intravenous bisphosphonates  
(Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal  
complications resulting from Paget's disease, multiple myeloma  
or metastatic cancer? .....         Do you drink alcoholic beverages? .....

Date Treatment began: \_\_\_\_\_      If yes, how much alcohol did you drink in the last 24 hours? \_\_\_\_\_

\_\_\_\_\_      If yes, how much do you typically drink in a week? \_\_\_\_\_

**WOMEN ONLY** Are you:  
Pregnant? .....  
Number of weeks: \_\_\_\_\_  
Taking birth control pills or hormonal replacement? .....  
Nursing? .....

**Joint Replacement.** Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? .....

Date: \_\_\_\_\_ If yes, have you had any complications? \_\_\_\_\_

**Allergies** - Are you allergic to or have you had a reaction to:      **Yes No DK**      **Yes No DK**

To all **yes** responses, specify type of reaction.

Local anesthetics .....         Metals .....

Aspirin .....         Latex (rubber) .....

Penicillin or other antibiotics .....         Iodine .....

Barbiturates, sedatives, or sleeping pills .....         Hay fever/seasonal .....

Sulfa drugs .....         Animals .....

Codeine or other narcotics .....         Food .....

\_\_\_\_\_      Other .....

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Yes	No	DK	Yes	No	DK	Yes	No	DK
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur.....	Anemia.....	Chronic pain.....	Sleep disorder.....					
Mitral valve prolapse.....	Blood transfusion.....	Diabetes Type I or II.....	Mental health disorders.....					
Artificial heart valves.....	If yes, date:_____	Eating disorder.....	Specify:_____					
Rheumatic fever.....	Hemophilia.....	Malnutrition.....	Recurrent Infections.....					
Cardiovascular disease.....	AIDS or HIV infection.....	Gastrointestinal disease.....	Type of infection:_____					
Angina.....	Arthritis.....	G.E. Reflux/persistent heartburn.....	Kidney problems.....					
Arteriosclerosis.....	Autoimmune disease.....	Ulcers.....	Night sweats.....					
Congestive heart failure.....	Rheumatoid arthritis.....	Thyroid problems.....	Osteoporosis.....					
Coronary artery disease.....	Systemic lupus erythematosus.....	Stroke.....	Persistent swollen glands in neck.....					
Damaged heart valves.....	Asthma.....	Glaucoma.....	Severe headaches/migraines.....					
Heart attack.....	Bronchitis.....	Hepatitis, jaundice or liver disease.....	Severe or rapid weight loss.....					
Low blood pressure.....	Emphysema.....	Epilepsy.....	Sexually transmitted disease.....					
High blood pressure.....	Sinus trouble.....	Fainting spells or seizures.....	Excessive urination.....					
Congenital heart defects.....	Tuberculosis.....	Neurological disorders.....						
Pacemaker.....	Cancer/Chemotherapy/Radiation Treatment.....	If yes, Specify:_____						
Rheumatic heart disease.....	Chest pain upon exertion.....							
Abnormal bleeding.....								

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? .....

Name of physician or dentist making recommendation: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have any disease, condition, or problem not listed above that you think I should know about? .....

Please explain: \_\_\_\_\_

**NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR COMPLETION BY DENTIST**

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# INFORMATION TO OUR PATIENTS

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**Our mission is to deliver the finest, most cost effective dental care available today. Following diagnosis the doctor will discuss with you our plan for treatment. We will also discuss the cost of today's and future treatments. Payment for all services is due prior to treatment. Because your dental plan may not cover the entire cost of your treatment, we offer several alternative payment options for your convenience.**

## PAYMENT OPTIONS

1. Cash or Check
2. MasterCard, Visa, or Discover
3. Monthly Payment Plan – The monthly payment is a separate line of credit for dental care only. It does not require payment now, or the use of your bank credit cards, leaving them free for non-healthcare purchases and emergencies. It also does not affect the balance of your other credit cards, and there are no annual fees. Monthly payments vary.

Please indicate below the payment option you wish:

- ( ) Cash or Check
- ( ) Visa, MasterCard, or Discover
- ( ) Monthly Payment Plan - If you choose this option, we will help you complete the simple application, and processing will only take a few minutes.

**I have read the 'INFORMATION TO OUR PATIENTS'.**

\_\_\_\_\_  
Signature of Patient/Responsible Party

\_\_\_\_\_  
Date