

**ADULT PATIENT INFORMATION**

PLEASE USE PEN

**NAME YOU PREFER** \_\_\_\_\_

- 
- MALE
- 
- FEMALE
- 
- 
- MARRIED
- 
- SINGLE
- 
- WIDOW

NAME \_\_\_\_\_  
FIRST MIDDLE INITIAL LASTMAILING ADDRESS \_\_\_\_\_  
APT # CITY STATE ZIP (+4 if known)

STREET ADDRESS (IF DIFFERENT) \_\_\_\_\_

BIRTH DATE \_\_\_\_\_ SS# \_\_\_\_\_ TELEPHONE ( \_\_\_\_\_ ) \_\_\_\_\_  
MONTH / DAY / YEAR HOME #( \_\_\_\_\_ ) \_\_\_\_\_ ( \_\_\_\_\_ ) \_\_\_\_\_ EMAIL \_\_\_\_\_  
WORK # CELL #

DO YOU WANT APPOINTMENTS CONFIRMED BY TEXT MESSAGE, EMAIL OR PHONE? \_\_\_\_\_

PLACE OF EMPLOYMENT \_\_\_\_\_ OCCUPATION \_\_\_\_\_

Other family members treated in our office \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_  No Referral**FAMILY INFORMATION****SPOUSE**

LAST FIRST MIDDLE

STREET CITY STATE ZIP

( \_\_\_\_\_ ) \_\_\_\_\_ ( \_\_\_\_\_ ) \_\_\_\_\_ ( \_\_\_\_\_ ) \_\_\_\_\_  
HOME TELEPHONE # EMPLOYER TELEPHONE # CELL PHONE #

BIRTH DATE (MONTH/DAY/YEAR) SS #

EMPLOYER

**ALTERNATE CONTACT (Required)****Someone not living at your residence**

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Telephone # ( \_\_\_\_\_ ) \_\_\_\_\_

**PERSON RESPONSIBLE FOR ACCOUNT****Please Check One**

- 
- Patient
- 
- Spouse
- 
- Guardian

**METHOD OF PAYMENT**

We file dental insurance as a courtesy for established patients. You must pay the estimated non-covered portion at the time of treatment. It is not our philosophy to allow insurance companies to dictate your dental care.

**We do not bill for services**

Payment in full is due at each appointment. We accept VISA, MasterCard, Discover and American Express for your convenience. We participate in CareCredit financing. If your driver's license number is on file here we will gladly accept a personal check. Returned checks are subject to \$25.00 NSF fee.

**AUTHORIZATION**

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 understand 24 hours notice is required if I need to cancel an appointment, in order to avoid a \$25 late cancellation fee. There will be a charge of \$50 if I simply do not show up for an appointment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. It is my responsibility to notify your office of future changes. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

x \_\_\_\_\_  
Signature  Self  Guardian

Date \_\_\_\_\_ State Driver's License # \_\_\_\_\_

**FINANCIAL REQUIREMENTS**

I have received, read and understand the office financial requirements.

Signature \_\_\_\_\_

# MEDICAL HISTORY

Medical Doctor \_\_\_\_\_  
FIRST & LAST NAME CITY

CIRCLE YES OR NO FOR EACH ITEM. **(PLEASE DO NOT USE ONE LARGE CIRCLE)** Have you ever had

Are you pregnant?	No	Yes	Repair of Heart Defect	No	Yes
Respiratory Disease	No	Yes	Previous Bacterial Endocarditis	No	Yes
If yes, what type? _____			Crohn's Disease	No	Yes
Asthma	No	Yes	Arthritis	No	Yes
Hepatitis	No	Yes	Hard of Hearing	No	Yes
Positive TB Test	No	Yes	Fainting Spells	No	Yes
HIV Positive	No	Yes	Seizures	No	Yes
Diabetes	No	Yes	If yes, date of last seizure _____		
High Blood Pressure	No	Yes	Currently have a shunt	No	Yes
Angina	No	Yes	Thyroid Problems	No	Yes
If yes, do you carry meds? _____	No	Yes	Blood Transfusion	No	Yes
Pacemaker	No	Yes	Organ Transplant	No	Yes
Stroke	No	Yes	Pin or Screw in a Joint	No	Yes
Heart Attack	No	Yes	Joint Replacement	No	Yes
Heart Disease	No	Yes	Wounds Heal Slowly	No	Yes
Heart Problems	No	Yes	Excessive Bleeding	No	Yes
Mitral Valve Prolapse	No	Yes	Take Blood Thinners	No	Yes
Congenital Heart Defect	No	Yes	Breast Implants	No	Yes

Gastric Bypass	No	Yes
Fibromyalgia	No	Yes
Migraines/Myofacial Pain	No	Yes
Reflux or GERD	No	Yes
Dry Mouth	No	Yes
Mouth Ulcers	No	Yes
Fever Blisters	No	Yes
Sinus Problems	No	Yes
Cancer	No	Yes
If yes, what type? _____		
Mastectomy R____ L____	No	Yes
Chemotherapy	No	Yes
Radiation	No	Yes
Family history of head or neck cancer	No	Yes
Alzheimer's	No	Yes
Osteoporosis Medications	No	Yes
Exposure to Human Papilloma Virus	No	Yes
Latex Sensitivity	No	Yes
Metal Sensitivity	No	Yes
Warts on Fingers	No	Yes
ADD or ADHD	No	Yes
Drug Dependency	No	Yes
Psychiatric Care	No	Yes

CIRCLE IF YOU ARE ALLERGIC TO: Codeine Penicillin Augmentin Tetracycline Motrin  
 Cleocin Cefitin Clindamycin Other \_\_\_\_\_ No Known Allergies

CIRCLE IF YOU ARE ALLERGIC TO: Kiwi Avocados Bananas Chestnuts

List any operations \_\_\_\_\_ None

List all medicines you take daily \_\_\_\_\_ None

Are you being treated for any medical problems not listed? \_\_\_\_\_ No

Do you take Garlic, Gingko, Ginseng, Ginger, Fish Oil or Flax Seed Oil? No Yes If yes, which one(s)? \_\_\_\_\_

Date \_\_\_\_\_ INITIAL CHARTING

Tooth #	Existing Restoration
1	
2	
3	
4 A	
5 B	
6 C	
7 D	
8 E	
9 F	
10 G	
11 H	
12 I	
13 J	
14	
15	
16	
17	
18	
19	
20 K	
21 L	
22 M	
23 N	
24 O	
25 P	
26 Q	
27 R	
28 S	
29 T	
30	
31	
32	

DENTAL HISTORY Circle Yes or No

Do you chew gum daily	Yes	No
Previous Orthodontics	Yes	No
Previous gum treatment	Yes	No
Have you ever whitened your teeth	Yes	No
Are you hard to numb for treatment	Yes	No
Mouth odor	Yes	No
Bad taste in mouth	Yes	No
Growths in mouth	Yes	No
Tooth injuries	Yes	No
Popping or pain in jaw joints	Yes	No
Previous TMJ treatment	Yes	No
Loose permanent teeth	Yes	No
Eat a lot of sweets	Yes	No
Do you smoke	Yes	No
Do you use smokeless tobacco	Yes	No
Brand: _____		
Nail biting	Yes	No
Grind teeth	Yes	No
Clench teeth	Yes	No
Bleeding gums	Yes	No
Do you floss daily	Yes	No
Do you always use a soft toothbrush	Yes	No
Do you use an electronic toothbrush	Yes	No
Bad dental experiences	Yes	No
Explain _____		
Do you crunch ice	Yes	No
Are you in discomfort now	Yes	No
What brand of tooth paste do you use _____		
Time since last dental cleaning _____		
Reaction to having dental work done _____		
Would you like to change anything in your mouth? _____		

Why did you change dentists? \_\_\_\_\_  
 Should we request Xrays Yes No  
 Previous dentist's name \_\_\_\_\_  
 I'd like info on: Whitening Teeth Closing Gaps Crooked Teeth  
 Do you wear a: partial Bite guard retainer  
 Frequent use of: Soda Diet Soda Coffee Tea  
Sports/Energy Drinks Wine Alcohol None

Informed of Perio and its consequences \_\_\_\_\_ BP



