WELCOME

PATIENT INFORMATION

Date _____

SSN# _____

Patient _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐M ☐F Age _____

Birthdate _____

Do you have dental insurance? _____

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (____) _____

Marital Status: Single, Married, Partnered, Divorced, Widowed

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home (____) _____ Work (____) _____ Ext ___ Cell (____) _____

Spouse's Work (____) _____ Best time to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (____) _____ Work Phone (____) _____

DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad Breath	☐Yes	☐No	Burning Sensation on tongue	☐Yes	☐No	Mouth pain, brushing	☐Yes ☐No
Bleeding Gums	☐Yes	☐No	Chew on one side of mouth	☐Yes	☐No	Orthodontic treatment	☐Yes ☐No
Blisters on lips or mouth	☐Yes	☐No	Cigarette, pipe or cigar smoking	☐Yes	☐No	Pain around ear	☐Yes ☐No
			Clicking or popping jaw	☐Yes	☐No	Periodontal treatment	☐Yes ☐No
			Dry mouth	☐Yes	☐No	Sensitivity to cold	☐Yes ☐No
			Fingernail biting	☐Yes	☐No	Sensitivity to heat	☐Yes ☐No
			Food collection between the teeth	☐Yes	☐No	Sensitivity to sweets	☐Yes ☐No
			Grinding teeth	☐Yes	☐No	Sensitivity when biting	☐Yes ☐No
			Gums swollen or tender	☐Yes	☐No	Sores or growths in your mouth	☐Yes ☐No
			Jaw pain or tiredness	☐Yes	☐No		
			Lip or cheek biting	☐Yes	☐No	How often do you floss? _____	
			Loose teeth or broken fillings	☐Yes	☐No	How often do you brush? _____	
			Mouth breathing	☐Yes	☐No	Do you use a mouth rinse? _____	

Special Comments/Concerns _____

_____

_____

_____

Health History

Physician's Name _____ Date of last visit _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐Yes ☐No	Fainting or dizziness	☐Yes ☐No	Scarlet Fever	☐Yes ☐No
Anemia	☐Yes ☐No	Glaucoma	☐Yes ☐No	Shortness of Breath	☐Yes ☐No
Arthritis, Rheumatism	☐Yes ☐No	Headaches	☐Yes ☐No	Sinus Trouble	☐Yes ☐No
Artificial Heart Valves	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Skin Rash	☐Yes ☐No
Artificial Joints	☐Yes ☐No	Heart Problems	☐Yes ☐No	Sleep Apnea/Snoring	☐Yes ☐No
Asthma	☐Yes ☐No	Hepatitis Type _____	☐Yes ☐No	Special Diet	☐Yes ☐No
Back Problems	☐Yes ☐No	Herpes	☐Yes ☐No	Stroke	☐Yes ☐No
Bleeding abnormally, with extractions or surgery	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Swollen Feet or Ankles	☐Yes ☐No
		Jaundice	☐Yes ☐No	Swollen Neck Glands	☐Yes ☐No
Blood Disease	☐Yes ☐No	Jaw Pain	☐Yes ☐No	Thyroid Problems	☐Yes ☐No
Cancer	☐Yes ☐No	Kidney Disease	☐Yes ☐No	Tonsillitis	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	Liver Disease	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Chemotherapy	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No	Tumor or growth on head or neck	☐Yes ☐No
Circulatory Problems	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No		
Congenital Heart Lesions	☐Yes ☐No	Nervous Problems	☐Yes ☐No	Ulcer	☐Yes ☐No
Cortisone Treatments	☐Yes ☐No	Pacemaker	☐Yes ☐No	Weight Loss, unexplained	☐Yes ☐No
Cough, persistent or bloody	☐Yes ☐No	Psychiatric Care	☐Yes ☐No	Radiation to head & neck area	☐Yes ☐No
Diabetes	☐Yes ☐No	Radiation Treatment	☐Yes ☐No	Have you ever taken medication for osteoporosis?	☐Yes ☐No
Emphysema	☐Yes ☐No	Respiratory Disease	☐Yes ☐No		
Epilepsy	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No	Are you taking blood thinners?	☐Yes ☐No

Medications

List any medications you are currently taking and the correlating diagnosis: (including over the counter medications)

_____

_____

_____

_____

Allergies

- ☐ Aspirin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other _____

_____

_____

_____

_____

_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all changes whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.