



Date \_\_\_\_\_ Patient Name \_\_\_\_\_ Name you wish to be called \_\_\_\_\_

If child, Parents name \_\_\_\_\_

Physical Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Work Phone \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ E-mail \_\_\_\_\_

Best Time and Place to Reach You \_\_\_\_\_

Sex:  M  F Age \_\_\_\_\_ Birth date \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Patient SS # \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Employer Address \_\_\_\_\_ Employer Phone \_\_\_\_\_

Spouse Name \_\_\_\_\_ Birth \_\_\_\_\_ SS# \_\_\_\_\_

Occupation \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

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IN CASE OF EMERGENCY PLEASE CONTACT (someone not living with you)

Name \_\_\_\_\_ Relationship to you \_\_\_\_\_

Address and Phone Number of Emergency Contact Person \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

Is patient covered by additional insurance?  yes  no Subscriber's name \_\_\_\_\_

Subscriber's Birth date \_\_\_\_\_ Subscriber's SS# \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date

DENTAL HISTORY

Reason for today's visit \_\_\_\_\_

Former Dentist \_\_\_\_\_ City/State \_\_\_\_\_

Date of last dental visit \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

Please check if you have any of the following:

- Bad breath
- Clicking or popping jaw
- Jaw joint pain
- Loose teeth
- Broken fillings
- Pain around ear
- Sensitivity to heat
- Sores or growths your mouth
- Bleeding gums
- Smoking
- Dry mouth
- Food collection between teeth
- Jaw pain or tiredness
- Mouth breathing
- Sensitivity to cold
- Sensitivity to biting
- Blisters on lips or mouth
- Fingernail biting
- Chewing tobacco
- Grinding teeth
- Clenching teeth
- Lip or cheek biting
- Orthodontic treatment
- Swollen or bleeding gums

Are you happy with the appearance of your teeth? \_\_\_\_\_ If you answered no, please explain \_\_\_\_\_

**WE STRIVE TO PROVIDE  
A POSITIVE CONTRIBUTION  
TO OUR PATIENT'S TOTAL WELL BEING  
THROUGH EXCELLENCE IN DENTISTRY,  
EDUCATION AND CARE**

**MEDICAL HISTORY**

**Physician's Name** \_\_\_\_\_ **Date of last visit** \_\_\_\_\_

Please check yes or no to indicate if you have had any of the following:

- |   |  |   |
|---|--|---|
| Yes/No  | Yes/No   | Yes/No  |
| <input type="radio"/> <input type="radio"/> AIDS                            | <input type="radio"/> <input type="radio"/> Headaches                              | <input type="radio"/> <input type="radio"/> Rheumatic fever                 |
| <input type="radio"/> <input type="radio"/> Anemia                          | <input type="radio"/> <input type="radio"/> Heart Murmur                           | <input type="radio"/> <input type="radio"/> Scarlet fever                   |
| <input type="radio"/> <input type="radio"/> Arthritis, Rheumatism           | <input type="radio"/> <input type="radio"/> Heart Problems                         | <input type="radio"/> <input type="radio"/> Shortness of breath             |
| <input type="radio"/> <input type="radio"/> Artificial heart valves         | <input type="radio"/> <input type="radio"/> Hepatitis (type _____)                 | <input type="radio"/> <input type="radio"/> Sinus trouble                   |
| <input type="radio"/> <input type="radio"/> Artificial joints               | <input type="radio"/> <input type="radio"/> Herpes                                 | <input type="radio"/> <input type="radio"/> Skin Rash                       |
| <input type="radio"/> <input type="radio"/> Asthma                          | <input type="radio"/> <input type="radio"/> High blood pressure                    | <input type="radio"/> <input type="radio"/> Special diet                    |
| <input type="radio"/> <input type="radio"/> Back problems                   | <input type="radio"/> <input type="radio"/> HIV positive                           | <input type="radio"/> <input type="radio"/> Stroke                          |
| <input type="radio"/> <input type="radio"/> Excessive bleeding with surgery | <input type="radio"/> <input type="radio"/> Jaundice                               | <input type="radio"/> <input type="radio"/> Swelling of feet or ankles      |
| <input type="radio"/> <input type="radio"/> Blood disease                   | <input type="radio"/> <input type="radio"/> Jaw Pain                               | <input type="radio"/> <input type="radio"/> Swollen neck glands             |
| <input type="radio"/> <input type="radio"/> Cancer                          | <input type="radio"/> <input type="radio"/> Joint replacement                      | <input type="radio"/> <input type="radio"/> Thyroid problems                |
| <input type="radio"/> <input type="radio"/> Chemical dependency             | <input type="radio"/> <input type="radio"/> Kidney disease                         | <input type="radio"/> <input type="radio"/> Tonsillitis                     |
| <input type="radio"/> <input type="radio"/> Chemotherapy                    | <input type="radio"/> <input type="radio"/> Low blood pressure                     | <input type="radio"/> <input type="radio"/> Tuberculosis                    |
| <input type="radio"/> <input type="radio"/> Circulatory problems            | <input type="radio"/> <input type="radio"/> Mitral valve prolapse                  | <input type="radio"/> <input type="radio"/> Tumor or growth of head or neck |
| <input type="radio"/> <input type="radio"/> Congenital heart lesions        | <input type="radio"/> <input type="radio"/> Nervous problems                       | <input type="radio"/> <input type="radio"/> Ulcer                           |
| <input type="radio"/> <input type="radio"/> Cortisone treatments            | <input type="radio"/> <input type="radio"/> Pacemaker                              | <input type="radio"/> <input type="radio"/> Venereal disease                |
| <input type="radio"/> <input type="radio"/> Cough, persistent or bloody     | <input type="radio"/> <input type="radio"/> Diabetes or family history of diabetes | <input type="radio"/> <input type="radio"/> Unexplained weight loss         |
| <input type="radio"/> <input type="radio"/> Epilepsy                        | <input type="radio"/> <input type="radio"/> Psychiatric care                       | <input type="radio"/> <input type="radio"/> Women:                          |
| <input type="radio"/> <input type="radio"/> Fainting or dizziness           | <input type="radio"/> <input type="radio"/> Radiation treatment                    | <input type="radio"/> <input type="radio"/> Are you pregnant?               |
| <input type="radio"/> <input type="radio"/> Glaucoma                        | <input type="radio"/> <input type="radio"/> Respiratory disease                    | <input type="radio"/> <input type="radio"/> Taking birth control pills?     |
|   |  | <input type="radio"/> <input type="radio"/> Breast-feeding?                 |

**MEDICATIONS**

Please list medications you are currently taking: \_\_\_\_\_

- ALLERGIES:**  None
- |   |  |
|---|--|
| <input type="radio"/> Aspirin                       | <input type="radio"/> Local Anesthetic |
| <input type="radio"/> Barbiturates (sleeping pills) | <input type="radio"/> Penicillin       |
| <input type="radio"/> Codeine                       | <input type="radio"/> Sulfa            |
| <input type="radio"/> Iodine                        | <input type="radio"/> Latex            |

Other \_\_\_\_\_

Pharmacy Name \_\_\_\_\_ Phone \_\_\_\_\_

I understand I am responsible for my account regardless of my insurance. I also understand that my insurance is an agreement between me and my insurance company. Balances over 90 days will be charged 1.5% per month interest (18% per year). I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my Dental needs. I understand that these records may be used for educational purposes.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

(The above is accurate to the best of my knowledge. I have read, agree to, and understand the statements listed above)