

Welcome! Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions concerns, do not hesitate to ask for assistance. We will be happy to help.

Patient Information (Please Print)

Name _____ Date _____
First MI Last
SS# _____ E-Mail Address _____

Address _____

City _____ State _____ Zip _____

Birth date _____ Home Phone # _____ Work Phone # _____

Cell Phone # _____ Where do you prefer calls directed? _____

Employer _____ Occupation _____

Are You: Minor ___ Married ___ Divorced ___ Widowed ___ Separated ___ Single ___

Spouse's or parents name _____ Workplace _____ Work # _____

Emergency Contact _____ Relationship _____ Phone # _____

WHOM MAY WE THANK FOR REFERING YOU? _____

Responsible Party

Name of person responsible for this account? _____

Relationship to patient _____ Phone # _____

Address _____ City _____ ST _____ Zip _____

Employer _____ Work Phone # _____

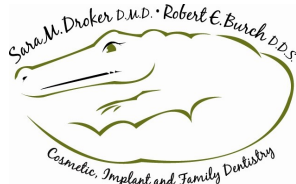
Insurance Information

Name of Insured _____ Relationship _____

Birth date _____ SS# _____ Date Employed _____

Employer _____ Work Phone # _____

Insurance Company _____ Group # _____ Employer # _____



Dental Information

Past dental treatment

YES

Family history of extensive decay?	
Treatment for periodontal (gum) disease?	
Family history of gum disease?	
Have you had orthodontics (braces)?	
Have you had oral surgery?	
Have you had any dental implants placed?	
Treatment for temporomandibular disorders?	
Do you wear a denture(s) or partial denture(s)?	

Do you have consistent problem with:

Yes

Dry mouth / excessive thirst?	
Sensitive teeth? Please circle: Hot Cold Pressure Sweets	
Mouth odors / bad taste?	
Cold sores / blisters / oral lesions?	
Are you aware of any swelling or lumps?	
Sore, bleeding gums?	
Loose teeth?	
Difficulty chewing?	
Food catches between teeth?	
Teeth / fillings break easily?	
Clenching or grinding habits?	
Do you hear popping, clicking or snapping?	
Do you have jaw pain?	
Are you nervous about dental work?	

Medical History

Current Medications (Prescription, Over the counter and Herbal)

Medication	Dosage	Frequency

Have you ever been treated for (please circle):

Multiple Myeloma Metastatic Cancer Pagets Disease Osteoporosis

Have you had IV therapy for any of the above listed ailments? Yes _____ No _____

Have you had **bisphosphonate** therapy? Yes _____ No _____ For how long? _____

Have you taken either (please circle)? Aredia Zometa

Have you taken oral **bisphosphonate**? Yes _____ No _____

Which kind (Please circle)? Actonel Boniva Fosmax Skeli Didronel

