Welcome

Thank you for selecting our dental health care team. We will strive to provide you with the best possible dental care. To help us meet all your dental health care needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us—we will be happy to help.

Name: _____
(First) *(Middle)* *(Last)*

Address: _____ *City:* _____ *State:* _____ *Zip:* _____

Home Phone: _____ *Cell Phone:* _____ *Work Phone:* _____

Social Security No. _____ *Date of Birth:* _____

Person Responsible for Account _____

Relationship to patient? _____

Address: _____ *City:* _____ *State:* _____ *Zip:* _____

Social Security No. _____ *birthdate:* _____

Name of employer _____ *Telephone:* _____

Employer address: _____

Occupation: _____ *Length employed:* _____

Spouse's name: _____

Social Security No. _____ *birthdate:* _____

Name of employer: _____ *Telephone:* _____

Employer address: _____

Occupation: _____ *Length employed:* _____

Dental Insurance Information:

Insured's Name: _____ *Insured's D.O.B.* _____ *Insured's S.S.N.:* _____

Insurance Co. _____ *Group No.:* _____

Do you have dual insurance coverage: Yes___ No___ If yes:

Insured's Name: _____ *Insured's D.O.B.* _____ *Insured's S.S.N.:* _____

Insurance Co. _____ *Group No.:* _____

Insured's employer: _____

Whom may we thank for referring you? _____

Any other family members seen by us? _____

In case of emergency, contact?

Name _____ *Relationship* _____

Home Phone _____ *Work Phone* _____

_____

Signature of Patient (parent, if patient is a minor) ***Date***

Patient Medical History

*Physician*_____ *Office Phone* _____ *Date of Last Exam* _____

	YES	NO
1. *Are you under medical treatment now?*	❑	❑
2. *Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?*	❑	❑
If yes, please explain.		
3. *Have you ever taken Phen-Fen/Redux?*	❑	❑
4. *Do you use tobacco?*	❑	❑
5. *Do you use controlled substances?*	❑	❑

	YES	NO
8. ***Are you allergic to or have you had any reactions to the following?***		
Local Anesthetics (e.g. Novocaine)	❑	❑
Penicillin or any other Antibiotics	❑	❑
Sulfa Drugs	❑	❑
Codeine	❑	❑
Aspirin	❑	❑
Any Metals (e.g. nickel, mercury, etc.)	❑	❑
Latex Rubber	❑	❑
Other (please list)_____		
9. ***Women Only:***		
a) Are you pregnant or think you may be pregnant?	❑	❑
b) Are you nursing?	❑	❑
c) Are you taking oral contraceptives?	❑	❑

7. *Do you have or have you had any of the following?*

	YES	NO
AIDS or HIV Infection	❑	❑
Anemia	❑	❑
Angina	❑	❑
Arthritis	❑	❑
Artificial Heart Valves	❑	❑
Asthma	❑	❑
Cancer	❑	❑
Cardiac Pacemaker	❑	❑
Chemotherapy	❑	❑
Chest Pains	❑	❑
Congenital Heart Defect	❑	❑
Cortisone Treatments	❑	❑
Diabetes	❑	❑
Endocarditis	❑	❑
Epilepsy / Convulsions	❑	❑
Emphysema	❑	❑
Fainting / Seizures	❑	❑
Glaucoma	❑	❑
Heart Trouble	❑	❑
Hepatitis & Jaundice (Type____)	❑	❑
High Blood Pressure	❑	❑
Joint Replacement or Implant	❑	❑
Kidney Diseases	❑	❑
Leukemia / Blood Disorder	❑	❑
Liver Disease	❑	❑
Low Blood Pressure	❑	❑
Radiation Therapy	❑	❑
Respiratory Problems	❑	❑
Stomach Troubles / Ulcers	❑	❑
Stroke	❑	❑
Thyroid Problem	❑	❑
Tuberculosis	❑	❑
Weight Loss, unexplained	❑	❑
*Other*_____	❑	❑

Are you taking any medication(s) including non-prescription medicine? ❑ *Yes* ❑ *No*

If yes, what medications are you taking _____

Patient Dental History

Name of Previous Dentist and Location _____ *Date of Last Exam* _____

	YES	NO
Do your gums bleed while brushing or flossing?	❑	❑
Are your teeth sensitive to hot or cold liquids/foods?	❑	❑
Do you feel pain to any of your teeth?	❑	❑
Do you have any sores or lumps in or near your mouth?	❑	❑
Have you had any head, neck or jaw injuries?	❑	❑
Have you ever experienced any of the following problems in your jaw?		
Clicking	❑	❑
Pain (joint, ear, side of face)	❑	❑
Difficulty in opening or closing	❑	❑
Difficulty in chewing	❑	❑
Do you have frequent headaches?	❑	❑

	YES	NO
Do you clench or grind your teeth?	❑	❑
Have you ever had any difficult extractions in the past?	❑	❑
Have you ever had any prolonged bleeding following extractions?	❑	❑
Have you had any orthodontic treatment?	❑	❑
Do you wear dentures or partials?	❑	❑
If yes, date of placement _____		
Do you like your smile?	❑	❑

*How many times a week do you floss?*____

*How many times a day do you brush?*____ *Type of bristles?* ❑ *Hard* ❑ *Medium* ❑ *Soft*

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

_____

Signature ***Date***

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

Below to be filled in at future appointments

Updates

Has there been any change in your health since your last dental appointment? ❑ *YES* ❑ *NO*

For what conditions? _____

Are you taking any new medications? _____ *If so, what?* _____

Patient's Signature _____ *Date* _____

Doctor's Signature _____ *Date* _____

Updates

Has there been any change in your health since your last dental appointment? ❑ *YES* ❑ *NO*

For what conditions? _____

Are you taking any new medications? _____ *If so, what?* _____

Patient's Signature _____ *Date* _____

Doctor's Signature _____ *Date* _____