Welcome

Age_____ Date_____

Patient's Name_____ Date of Birth _____ ☐ Male ☐ Female
Last First Initial

If Minor: Parent's Name_____

How do you wish to be addressed? _____
Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor ☐

Residence Address_____

City/State/Zip Code_____

Business Address_____

Telephone: Res._____ Bus. _____

Fax_____ Cell Phone #_____

Email _____

Patient/Parent Employer _____

Present Position _____

How Long Held_____

Spouse/Parent Name _____

Spouse's Employer _____

Present Position _____

How Long Held_____

Person Responsible for this account_____

Driver's License No. _____

Method of Payment: Cash ☐ Credit Card ☐ Insurance ☐

Purpose of Visit _____

Other Family Members in this Practice _____

_____

Whom may we thank for this referral? _____

Patient/Parent Social Security No. _____

Spouse/Parent Social Security No. _____

Someone to notify in case of emergency not living with you

_____

Secondary emergency contact

_____

DENTAL INSURANCE 1ST COVERAGE

Employee Name _____ Date of Birth _____
Relationship to patient _____
Employer Name _____ Yrs._____
Name of Insurance Co._____
Address _____
_____
Telephone _____
Program or policy# _____
Social Security No._____
Union Local or Group_____

DENTAL INSURANCE 2ND COVERAGE

Employee Name _____ Date of Birth _____
Relationship to patient _____
Employer Name _____ Yrs._____
Name of Insurance Co._____
Address _____
_____
Telephone _____
Program or policy# _____
Social Security No._____
Union Local or Group_____

CONSENT:
I consent to all diagnostic procedures and treatment required for proper dental care by the dentist.

I consent to the dentist's use and disclosure of my records (or my child's records) to the insurance company to obtain payment, and for those activities and health care operations that are related to treatment or payment.

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE

_____

DATE_____

REGISTRATION

Welcome

Patient's Name_____
Last First Initial Date of Birth

1. Reason for initial visit_____
2. Are you aware of any problem(s)?_____
3. When was your last dental visit?_____
4. What services were provided?_____
5. Name of previous dentist_____
   Address:_____Phone No._____
6. How long since your last teeth cleaning?_____

CIRCLE APPROPRIATE ANSWER. IF YOU DON'T KNOW CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

7. Did you see your dentist regularly? . . . . . YES NO
   How often?_____
8. Were dental x-rays taken? . . . . . YES NO
9. Have you lost any teeth or have any teeth been removed? . . . . . YES NO
   Why?_____
10. Have any teeth been replaced?_____
11. How have they been replaced?_____
    a. Fixed bridge_____Age_____
    b. Removable bridge_____Age_____
    c. Denture_____Age_____
    d. Implant_____Age_____
12. Are you unhappy with the replacement? . . . . . YES NO
    If yes, explain_____
13. Would you like to know about permanent replacements? . . . . . YES NO
14. Have you ever had any problems or complications with previous dental treatment? . . . . . YES NO
15. Do you clench or grind your teeth?. . . . . YES NO
16. Does your jaw click or pop? . . . . . YES NO
17. Have you experienced any pain or soreness in the muscles of your face or around your ear? . . . . . YES NO
18. Do you have frequent headaches, neck aches or shoulder aches? . . . . . YES NO
19. Does food get caught in your teeth? . . . . . YES NO
20. Are any of your teeth sensitive to: ☐ Hot? ☐ Cold? ☐ Sweets? ☐ Pressure?
21. Do your gums bleed or hurt?. . . . . YES NO
    When/how often?_____
22. Do you feel your breath is offensive at times?. . . . . YES NO
23. Have you ever had gum treatment or surgery? . . . . . YES NO
    What?_____
    Where?_____
    Year?_____
24. Are any of your teeth loose, tipped, shifted or chipped?. . . . . YES NO
25. Are you unhappy with the appearance of your teeth? . . . . . YES NO
26. How do you feel about your teeth in general?_____
27. How often do you brush your teeth?_____When?_____
28. Do you use dental floss?. . . . . YES NO
    How often?_____
29. Have you had any orthodontic work?
30. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?_____

Do you have any questions or concerns? . . . . . YES NO

COMMENTS

I CERTIFIY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN'S SIGNATURE_____DATE_____

DENTIST'S SIGNATURE_____DATE_____

ANEST.

DENTAL HISTORY

MED. ALERT

Patient's Name_____
Last First Initial Date of Birth

CIRCLE APPROPRIATE ANSWER. IF YOU DON'T KNOW CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

1. Physician's Name_____
   Address_____
   City/State/Zip_____ Phone No._____
2. Are you under a physician's care? . . . . . YES NO
   Since when?_____ Why_____
3. When was your last complete physical exam?_____
4. Are you taking any medication or substances: . . . . . YES NO
   (If yes, please list medications in comments section or on the back of this form.)
5. Do you routinely take health related substances: (Vitamins, herbal supplements, natural products) . . . . . YES NO
6. Are you allergic to any medications or substances? (please list) . . . . . YES NO
7. Do you have any other allergies or hives?. . . . . YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? . . . . . YES NO
9. Are you sensitive to any metals or latex?. . . . . YES NO
10. Are you pregnant or suspect you may be?. . . . . YES NO
11. Do you use any birth control medications?. . . . . YES NO
12. Have you ever been treated for or been told you might have heart disease?. . . . . YES NO
13. Do you have a pacemaker, an artificial heart valve implant, or been diagnosed with mitral valve prolapse?. . . . . YES NO
14. Have you ever had rheumatic fever?. . . . . YES NO
15. Are you aware of any heart murmurs? . . . . . YES NO
16. Do you have high or low blood pressure? . . . . . YES NO
17. Have you ever had a serious illness or major surgery? . . . . . YES NO
    If so, explain_____
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition?. . . . . YES NO
19. Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis? . . . . . YES NO
20. Do you have inflammatory diseases, such as arthritis or rheumatism? . . . . . YES NO
21. Do you have any artificial joints/prosthesis?. . . . . YES NO
22. Do you have any blood disorders, such as anemia, leukemia, etc.? . . . . . YES NO
23. Have you ever bled excessively after being cut or injured? . . . . . YES NO
24. Do you have any stomach problems? . . . . . YES NO
25. Do you have any kidney problems?. . . . . YES NO
26. Do you have any liver problems?. . .. . YES NO
27. Are you diabetic? . . . . . YES NO
28. Do you have fainting or dizzy spells? . . . . . YES NO
29. Do you have asthma? . . . . . YES NO
30. Do you have epilepsy or seizure disorders? . . . . . YES NO
31. Have you tested HIV positive? . . . . . YES NO
32. Do you have AIDS?. . . . . YES NO
33. Have you had or do you test positive for hepatitis? . . . . . YES NO
34. Do you or have you had T.B.? . . . . . YES NO
35. Do you smoke, chew, use snuff or any other forms of tobacco?. . . . . YES NO
36. Do you regularly consume more than one or two alcoholic beverages a day? . . . . . YES NO
37. Do you habitually use controlled substances?. . . . . YES NO
38. Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products?. . . . . YES NO
39. Do you have any other health problems not listed? If so, explain_____
    _____
40. Would you like to speak to the Doctor privately about any problems?. . . . . YES NO

COMMENTS

I CERTIFIY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN'S SIGNATURE_____ DATE_____

DENTIST'S SIGNATURE_____ DATE_____

ANEST.

MEDICAL HISTORY

MED. ALERT

PATIENT'S NAME _____
Last First Initial

I hereby authorize payment directly to _____
of the dental benefits otherwise payable to me. (DENTIST'S NAME)

_____
SIGNATURE (INSURED INDIVIDUAL)

_____
DATE

Signature is valid for two years from the above date, unless revoked by me at an earlier date.

_____

_____
ATTENDING D.D.S. NAME

is authorized to provide any insurance company(s), claim administrators(s) and consulting health care professionals, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits.

This authorization is valid for the term of coverage of the policy or contract, in force on this date only, or for two years, which ever is shorter.

I know I have a right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

_____
PATIENT OR AUTHORIZED INDIVIDUAL'S SIGNATURE DATE

SIGNATURE ON FILE