



## Patient Information

Date \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name

\_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Sex  M  F Driver License # \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Married  Widowed  Single  Minor

Separated  Divorced  Partnered for \_\_\_\_\_ years

Patient Employer/School \_\_\_\_\_

Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_

\_\_\_\_\_

Employer/School Phone (\_\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

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

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



## Dental Insurance

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

**ASSIGNMENT AND RELEASE**  
 I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
 Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
 Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
 Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
 Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_



## Phone Numbers

Home (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Spouse's Work (\_\_\_\_\_) \_\_\_\_\_ Best time and place 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 _____	Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____
	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	

# Dental Registration and History



# MEDICAL HISTORY

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you every had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No \_\_\_\_\_
- Do you use tobacco?  Yes  No \_\_\_\_\_
- Do you use controlled substances?  Yes  No \_\_\_\_\_

Women:  
Are you: Pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following?

- Aspirin  Penicillin  Codeine  Local Anesthetics  Acrylic  Metal  Latex  Sulfa Drugs
- Other - If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following?

- |                           |  |                           |  |                            |  |
|---------------------------|--|---------------------------|--|----------------------------|--|
| AIDS/HIV Positive         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive Thirst          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alzheimer's Disease       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting Spells/Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anaphylaxis               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Cough            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain in Jaw Joints         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Diarrhea         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parathyroid Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Headaches        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/Gout            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Genital Herpes            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatments       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent Weight Loss         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joint          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Renal Dialysis             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack/Failure      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatism                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Transfusion         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Pacemaker           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breathing Problem         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Trouble/Disease     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shingles                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bruise Easily             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis B or C          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Spina Bifida               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pains               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach/Intestinal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cold Sores/Fever Blisters | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling of Limbs          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Convulsions               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hives or Rash             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Medicine        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypoglycemia              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Irregular Heartbeat       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Drug Addiction            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors or Growths          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Easily Winded             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Leukemia                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy or Seizures      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Yellow Jaundice            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Excessive Bleeding        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung Disease              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____                | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Comments \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Initial \_\_\_\_\_