Patient Information:

Last Name: First Name: MI:

Name you Prefer: Date of Birth: Social Security #:

Address: City: State: Zip:

Home Phone: Mobile Phone: Work Phone: Ext:

Email:

Gender: M: [ ] F:[ ] O: [ ] Married/Domestic Partner: Y:[ ] N:[ ]

How did you hear about us? Drive by: [ ] Social Media/Website:[ ] Insurance:[ ] Family/Friend:[ ]

Are any other members of your household a patient with us? Y:[ ] N:[ ] Name:

*Primary Insurance:

Insurance Company Name:

Primary Subscribers Name(If different from the patient): Date of Birth:

Relationship to Subscriber: Spouse:[ ] Parent:[ ] Other:[ ] Subscribers Social Security:

ID Number: Group Number: Effective Date:

Claims Address:

Claims Phone Number:

*Secondary Insurance:

Insurance Company Name:

Primary Subscribers Name(If different from the patient): Date of Birth:

Relationship to Subscriber: Spouse:[ ] Parent:[ ] Other:[ ] Subscribers Social Security:

ID Number: Group Number: Effective Date:

Claims Address:

Claims Phone Number:

*Payment is due at time of service. If patient is covered by insurance, the insurance company will be billed. It is your responsibility, however, to pay your portion at time of service. If the necessary, please discuss other financial arrangements with our billing office.

Emergency Contact:

Last Name: First Name: Spouse/Partner: Y:[ ] N:[ ]

Primary Phone: Secondary Phone: Patient Here: Y:[ ] N:[ ]

I acknowledged that I am financially responsible for all charges whether or not paid by insurance. The undersigned agrees to pay for all cost and expenses. I hereby authorize the office to release information necessary to secure the payment of benefits.

Signature:

Patient Signature (or Guardian): Date:

Name________________________________DOB _________

PRIMARY PHYSICIAN INFORMATION

Physician: Telephone:

Clinic/Facility:

MEDICAL HISTORY

GENERAL HEALTH: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

☐ Y ☐ N Under a physician's care now?

☐ Y ☐ N Any hospitalization in the past 5 years?

☐ Y ☐ N Any serious illnesses/surgeries ?

☐ Y ☐ N Use tobacco in any form? If Yes, Type:

☐ Y ☐ N Is pre-medication required before dental visits due to heart condition or artificial joint?

☐ Y ☐ N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: ☐ Y ☐ N Currently nursing? ☐ Y ☐ N Currently pregnant? Due Date:

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐ Y ☐ N
If yes, please describe:

Is there anything important about your medical condition we have not asked? ☐ Y ☐ N If yes, please describe:

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ NONE

☐ ACID REFLUX	☐ BULIMIA	☐ HEAD INJURIES	☐ PREGNANCY
☐ ADHD	☐ CANCER/MALIGNANCY	☐ HEART ATTACK	☐ PSYCHIATRIC TREATMENT
☐ AIDS/HIV	☐ CHEMOTHERAPY	☐ HEART DISEASE	☐ RADIATION
☐ ANEMIA	☐ CHEMICAL DEPENDENCY	☐ HEART MURMUR	☐ RESPIRATORY DISEASE
☐ ANOREXIA	☐ COUGH, PERSISTENT	☐ HEPATITIS	☐ RHEUMATIC FEVER
☐ ANXIETY	☐ DEPRESSION	☐ HIGH BLOOD PRESSURE	☐ SINUS PROBLEMS
☐ ARTIFICIAL HEART VALVE	☐ DIABETES	☐ KIDNEY DISEASE	☐ STROKE
☐ ARTIFICIAL JOINTS	☐ DIZZINESS/FAINTING	☐ JAW PAIN	☐ THYROID CONDITION
☐ ARTHRITIS	☐ EPILEPSY/SEIZURES	☐ LIVER PROBLEMS	☐ TUBERCULOSIS
☐ ASTHMA	☐ EXCESSIVE BLEEDING	☐ MENTAL DISORDER	☐ ULCERS
☐ BACK PROBLEMS	☐ FREQUENT HEADACHES	☐ PACEMAKER	☐ VENEREAL DISEASE
☐ BLOOD DISEASE	☐ HEARING PROBLEMS	☐ OTHER – PLEASE LIST:	

ALL PATIENTS: ARE YOU **ALLERGIC** TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ NONE

☐ ASPIRIN	☐ CODEINE	☐ LACTOSE INTOLERANCE	☐ Seasonal
☐ ANESTHETIC – LOCAL	☐ DAIRY	☐ METAL SENSITIVITY	☐ SULFA DRUGS
☐ BARBITURATES	☐ LATEX	☐ NITROUS OXIDE SEDATION	☐ PENICILLIN/OTHER ANTIBIOTICS

☐ OTHER – PLEASE LIST:

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY) ☐ NONE

☐ ANTIBIOTICS/SULFA DRUGS	☐ ANTIHISTAMINES/ALLERGY	☐ DAILY ASPIRIN	☐ BLOOD PRESSURE MEDICATIONS
☐ BLOOD THINNERS	☐ CANCER/CHEMO MEDICATIONS	☐ CORTISONE/STEROIDS	☐ HEART MEDICATION/DIGITALIS
☐ INSULIN	☐ NITROGLYCERIN	☐ ORAL CONTRACEPTIVES	☐ OSTEOPOROSIS MEDICATIONS
☐ OTHER DIABETIC MEDICATIONS	☐ RECREATIONAL DRUGS	☐ THYROID MEDICATIONS	☐ TRANQUILIZERS
☐ OTHER (PLEASE LIST BELOW)			

DRUG NAME	DOSAGE	REASON PRESCRIBED

PREVIOUS DENTIST INFORMATION

Dentist: ______ Telephone: ______

Clinic/Facility: ______

Address: ______

CITY ST ZIP CODE

DENTAL HISTORY

ORAL HEALTH: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

Date of Last Dental Visit: ______ Treatment Type: ______

☐Y☐N Are you currently having dental discomfort? If yes, explain: ______

☐Y☐N Any unhappy/unpleasant dental experiences? If yes, explain: ______

☐Y☐N Any injuries to mouth/teeth/head? If yes, explain: ______

☐Y☐N Any missing teeth other than wisdom teeth or orthodontic extractions?

☐Y☐N Have missing teeth been replaced?

☐Y☐N Orthodontic appliances now or in the past?

☐Y☐N Gums bleed when brushing or flossing?

☐Y☐N Concerned about gum disease? History of gum disease? ☐Y☐N

☐Y☐N Any concerns about the appearance of your teeth?

☐Y☐N Does it hurt to bite or chew?

☐Y☐N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐Y☐N

☐Y☐N Do you want to become a regular continuing care patient in our practice?

☐Y☐N Do you want your mouth properly restored and pain free?

☐Y☐N Does any type of dental treatment make you nervous? If yes, please explain below:

The most important concerns regarding my dental treatment are:

What factors are most important for your satisfaction with our office?

Any additional concerns/comments?

Signature: ______ Date: ______

Patient name: ______