Welcome

You

Name ______________________________ Today's Date ____ / ____ / ____
last first MI

Address ______________________________ Sex: ☐Male ☐Female
Street City State Zip

E-mail address ______________________________ Social Security # ____________________

I prefer to be called (nickname) ______________________________

Phone

Home ______________ Work ______________

Fax ______________ Cell ______________

Best time to reach you ______________________

day? ______________ where? ______________

Birth date ____ / ____ / ____

Check box that applies

☐ Minor ☐ Single

☐ Married ☐ Divorced

☐ Widowed ☐ Separated

Patient's or guardian's employer ______________________________ Occupation ____________________

Employer Address ______________________________
Street City State Zip

How long there? ____________________

Responsible party *if other than yourself*

Name ______________________________ Relation ____________________
last first MI

Home Phone ____________________ Social Security # ____________________

Work Phone ____________________ Ext. ________

Billing Address ______________________________
Street City State Zip

Spouse information

His/Her Name ______________________________ Birth date ____ / ____ / ____
last first MI

Social Security # ____________________ Drivers License # ____________________

Employer ______________________________ Work Phone ____________________ Ext. ______

In the event of an emergency, who should we contact?

Name ______________________________ Relationship ____________________

Work Phone ____________________ Ext. ________ Home Phone ____________________

Who may we thank for referring you? ______________________________

Insurance Information

Primary Insurance

Coverage		
Dental	yes	no
Medical	yes	no
Orthodontic	yes	no

Insurance Company name ______________________________

Phone number __________________________

Group # (plan, local or policy #) _________________________

Insurance Company Address ____
Street/PO box City State Zip

Insured's Name __________________ Insured's Social Security # ______________________________

Insured's Birth date _____ / _____ / _____ Relation ____________________

Insured's Employer _____________________________

Employer's Address ____
Street/PO box City State Zip

Secondary Insurance

Coverage		
Dental	yes	no
Medical	yes	no
Orthodontic	yes	no

Insurance Company name ______________________________

Phone number __________________________

Group # (plan, local or policy #) _________________________

Insurance Company Address ____
Street/PO box City State Zip

Insured's Name __________________ Insured's Social Security # ______________________________

Insured's Birth date _____ / _____ / _____ Relation ____________________

Insured's Employer _____________________________

Employer's Address ____
Street/PO box City State Zip

Authorizations

I certify that I have read and understand the above information. I have answered the questions to the best of my knowledge. I also realize it is my responsibility to inform this office of any changes in my medical status. I understand providing incorrect information may be dangerous to my health. I authorize the dental staff to perform the necessary dental services I may need.

Signature

____
patient, parent, or guardian

______ / ______ / ______
today's date

I certify that I am covered by ________________________
Insurance Company and I assign directly to

Dr. ____________________________

All insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature

____

Dental History

Why have you come to the dentist today? ____

____

Are you currently in pain? Y N
Do you require antibiotics before dental treatment? Y N
Are you aware of any broken teeth or fillings? Y N
Are your teeth sensitive to sweet/sour? Y N
Do you feel pain in any of your teeth? Y N
Do you have any sores or lumps in or near your mouth? Y N
Have you had any head, neck or jaw injuries? Y N
Have you ever experienced any of the following problems in your jaw?
- a) clicking Y N
- b) Pain (joint, ear, side of face) Y N
- c) difficulty opening/ closing Y N
- d) difficulty chewing Y N

Do you have frequent headaches? Y N
Do you have frequent sinus pain or pressure? Y N
Do you clench or grind your teeth? Y N
Do you bite your lips/ cheeks frequently? Y N
Have you had any orthodontic work? Y N
Have you ever had prolonged bleeding following extractions? Y N
Have you ever had instruction on the correct method of brushing your teeth? Y N
Have you ever had instructions on the care of your gums? Y N
Have you experienced problems associated with previous dental work? Y N
Your current dental health is Good Fair Poor
Do you floss daily? Y N
Do you brush daily? Y N
Type of bristles on your toothbrush Hard Medium Soft
Do you use anything in addition to brushing and flossing? Y N
If so, what? ______________________________
How long do you use a toothbrush before replacing it?
____

Do your gums ever bleed while brushing or flossing? Y N
Do they ever itch? Y N
Have you ever had periodontal disease? Y N
Do you have mobility in your teeth? Y N
Do you still have your wisdom teeth? Y N
Would you like fresher breath? Y N
Would you like whiter teeth? Y N
Are you happy with the way your smile looks? Y N
If not, what would you change? ______________________________
____
How have your previous dental experiences been in the past? *Excellent* *Mediocre* *Frightening/painful*
If frightening, what caused it? ______________________________
____
What can we do to help you with this? ______________________________
____
Have you had regular checkups and cleanings? Y N
Last visit date to a dentist ______________________________
What was done at your last visit? ______________________________
____
If applicable, why have you neglected your dental health so long?
Money *Time* *Procrastination* *Pain/fear*
Why did you leave your previous dentist? ______________________________
____
Have you lost any teeth? __________ **If yes, has it ever been recommended that they be replaced?** Y N
Do any members of you family where dentures? Y N
If so, did they lose them at a young age? Y N

Medical History

Do you have a personal physician? Y N **Physician's name** ______________________________

Office Address ______________________________

Phone Number ______________________________ **Date of last visit** _____ / _____ / _____

Your current physical health is Good Fair Poor

Are you currently under the care of a physician? Y N

Please Explain ______________________________

Do you smoke or use tobacco in any other form? Y N

For Women

Are you currently taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Unsure ☐ Yes ☐ No

Week # ________

Are you nursing? ☐ Yes ☐ No

Medical History cont'd

Allergies		
Aspirin	Y	N
Acrylic	Y	N
Barbiturates	Y	N
Codeine	Y	N
Dental Anesthetics	Y	N
Erythromycin	Y	N
Gluten	Y	N
Jewelry/ Metals	Y	N
Latex	Y	N
Penicillin	Y	N
Sedatives	Y	N
Sulfa Drugs	Y	N
Tetracycline	Y	N
Other	Y	N

If other, please list ________________________________

____

Medications you are currently taking		
Acetaminophen	Y	N
Antibiotics	Y	N
Antihistamines	Y	N
Aspirin	Y	N
Blood Thinners	Y	N
Blood Pressure Medicine	Y	N
Cold Remedies	Y	N
Digitalis/ Heart Medication	Y	N
Insulin/ Diabetes Drugs	Y	N
Nitroglycerin	Y	N
Recreational Drugs	Y	N
Steroids/ Cortisone	Y	N
Thyroid Medicine	Y	N
Tranquilizers	Y	N
Other	Y	N

If other, please list ________________________________

____

Have you ever taken Phen-Fen? Also known as Redux or Pondimin. Yes No

Have you taken any of the following for bone density? (please circle)

Actonel (risedronate)	Boniva (ibandronate)	Fosamax (alendronate)	Skelid (Tiludronate)
Didronel (Etidronate)	Aredia (pamidronate)	Zometa (zolendronic acid)	Bonefos (Clodronate)

Do you or have you experienced the following?

Angina	Y	N	Glaucoma	Y	N	Persistent Cough	Y	N
Abnormal Bleeding	Y	N	Hay Fever	Y	N	Psychiatric Problems	Y	N
Alcohol Abuse	Y	N	Headaches	Y	N	Radiation Treatment	Y	N
Anemia	Y	N	Heart Attack	Y	N	Recent Weight Loss	Y	N
Arthritis	Y	N	Heart Disease	Y	N	Respiratory Problems	Y	N
Artificial bones/ joints	Y	N	Heart Murmur	Y	N	Rheumatic Fever	Y	N
Artificial valves	Y	N	Heart Surgery	Y	N	Scarlet Fever	Y	N
Asthma	Y	N	Hemophilia	Y	N	Seizures	Y	N
Blood Transfusion	Y	N	Hepatitis	Y	N	Sexually Transmitted Disease	Y	N
Cancer	Y	N	Herpes	Y	N	Shingles	Y	N
Chest Pains	Y	N	High Blood Pressure	Y	N	Sickle Cell Disease	Y	N
Chemotherapy	Y	N	HIV+/ AIDS	Y	N	Sinus Problems	Y	N
Chicken Pox	Y	N	Hospitalized for any reason	Y	N	Steroid Therapy	Y	N
Colitis	Y	N	Joint Replacement/implant	Y	N	Stomach Troubles	Y	N
Congenital Heart Defect	Y	N	Kidney Problems	Y	N	Stroke	Y	N
Diabetes	Y	N	Leukemia	Y	N	Swollen Ankles	Y	N
Difficulty Breathing	Y	N	Liver Disease	Y	N	Thyroid Problems	Y	N
Drug Abuse	Y	N	Low Blood Pressure	Y	N	Tonsillitis	Y	N
Emphysema	Y	N	Lupus	Y	N	Tuberculosis (TB)	Y	N
Epilepsy	Y	N	Mitral Valve Prolapse	Y	N	Ulcers	Y	N
Fever Blisters	Y	N	Pacemaker	Y	N	Venereal Disease	Y	N
Frequently Tired	Y	N						

Any other complications not stated above, please list ________________________________

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Any other comments you may have ________________________________

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