Welcome

Date_____

Patient Information (confidential)

Name_____ Birthdates_____
Address_____ Phone #_____
Email _____Cell Phone#_____

Check Appropriate: ____Minor ____Single ____Married ____Separated ____Divorced ____Widowed

If Student, Name/Address of School/College_____F/T _ ___ P/T ____
Patient or Parent/Guardian Employer_____Work Phone#_____

Spouse or Parent/Guardian's Name_____ _____ Phone # _____
Employer Name/Address _____Work Phone#_____
Whom may we thank for Referring You? _____
Person to Contact in Case of an Emergency_____Phone #_____

Responsible Party
Name of Person Responsible for this Account_____Relationship to Patient_____
Address _____ Home Phone # _____ _____
Email _____ Cell Phone# _____
Driver's License _____ Birthdates _____
Employer _____ Work Phone # _____

Insurance Information
Name of Subscriber (Insured) _____Birthdates _____Relationship to Patient _____
Insurance Company Name _____ Phone # _____
Subscriber/Member ID # _____ Group # _____
Employer Name _____

Insurance Information (if any additional)
Name of Subscriber (Insured) _____Birthdates _____Relationship to Patient _____
Insurance Company Name _____ Phone # _____
Subscriber/Member ID # _____ Group # _____
Employer Name _____

Patient Medical History

Physician _____Office Phone # _____Date of Last Exam _____

1. Are you under medical Treatment now: ___ YES ___NO
2. Have you ever been hospitalized for surgery Or serious illness in the last 5 years? ___YES ___NO
3. Are you taking any medication(s) including non-prescription medicine: ___YES ___NO
   If YES, list medication(s)_____
   _____
4. Have you ever taken Fen-Phen/Redux? ___YES ___NO
5. Have you ever taken Fosamex, Boniva, Actonel or any cancer medications containing bisphosphonates?

6. Do you use tobacco? ___YES ___NO
7. Do you use controlled substances? ___YES ___NO
8. Are you wearing contact lenses? ___YES ___NO

9. Any allergies or have you had any reactions to the following:
   Local Anesthetics, (e.g. Novocain) ___YES ___NO
   Penicillin or any other Antibiotics ___YES___NO

Sulfa Drugs	___YES ___NO	Barbiturates	___YES___NO
Sedatives	___YES ___NO	Iodine	___YES ___NO
Aspirin	___YES ___NO	Latex Rubber	___YES ___NO
Any Metals (e.g. nickel,mercury,etc.)			___YES ___NO

Are you pregnant ___YES ___NO Are you nursing ___YES ___NO
Are you taking oral contraceptives: ___YES ___NO

Other: _____

10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) ___YES ___NO

11. Do you have or have you had any of the following:

High Blood Pressure	___YES ___NO	Rheumatic Fever	___YES ___NO	Epilepsy/Convulsions	___YES ___NO
Heart Attack/Failure	___YES ___NO	Diabetes	___YES ___NO	Easily Winded	___YES ___NO
Heart Disease	___YES ___NO	Asthma	___YES ___NO	Leukemia	___YES ___NO
Heart Murmur	___YES ___NO	Low Blood Pressure	___YES ___NO	Hay Fever/Allergies	___YES ___NO
Angina	___YES ___NO	Frequently Tired	___YES ___NO	Tuberculosis	___YES ___NO
Cardiac Pacemaker	___YES ___NO	Anemia	___YES ___NO	Radiation Therapy	___YES ___NO
Chest Pains	___YES ___NO	Emphysema	___YES ___NO	Glaucoma	___YES ___NO
Stroke	___YES ___NO	Cancer	___YES ___NO	Recent Weight Loss	___YES ___NO
Mitral Valve Prolapse	___YES ___NO	Arthritis	___YES ___NO	Liver Disease	___YES ___NO
Artificial Heart Valves	___YES ___NO	Joint Replacement or Implant	___YES ___NO	Fainting/Seizures	___YES ___NO
Kidney Diseases	___YES ___NO	Hepatitis/Jaundice	___YES ___NO	Respiratory Problems	___YES ___NO
AIDS or HIV Infection	___YES ___NO	Sexually Transmitted Diseases	___YES ___NO	Swollen Ankles	___ YES___NO
Thyroid Problem	___YES ___NO	Stomach Troubles/Ulcers	___YES ___NO	Psychiatric Care	___YES ___NO
Sinus Trouble	___YES ___NO	Alzheimer's Disease	___YES ___NO	Diabetes	___YES ___NO
Herpes	___YES ___NO	Cold Sores/Fever Blisters	___YES ___NO	Other_____	YES ___NO

Patient Dental History

Name of Previous Dentist and Location_____ Date of Last Exam _____

Do your gums bleed while brushing or flossing? ___YES ___NO
Are your teeth sensitive to hot or cold liquids/foods: ___YES ___NO
Are your teeth sensitive to sweet or sour liquids/foods? ___YES ___NO
Do you feel pain to any of your teeth? ___YES ___NO
Do you have any sores or lumps in or near your mouth? ___YES ___NO

Have you had any head, neck, or jaw injuries? ___YES ___NO
Have you ever experienced any of the following problems in your jaw:
- Clicking ___YES ___NO
- Pain (joint, ear, side of face) ___YES ___NO
- Difficulty in opening or closing ___YES ___NO
- Difficulty in chewing ___YES ___NO

Do you have frequent headaches? ___YES ___NO
Do you clench or grind your teeth? ___YES ___NO
Do you bite your lips or cheeks frequently? ___YES ___NO
Have you ever had any difficult extractions? ___YES ___NO
Have you had any prolonged bleeding after extractions? ___YES ___NO
Have you had any orthodontic treatment? ___YES ___NO
Do you wear dentures or partials: ___YES ___NO
if yes, date of placement: _____
Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ___YES ___NO
Do you like your smile? ___YES ___NO

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependent

Signature of patient (or parent/guardian of minor) _____Date