

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date _____	Social Security Number _____
Name _____ Last Name First Name Middle Initial	Drivers License # and State _____
Home Address _____	<input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Minor <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered for _____ years
City _____ State _____ Zip _____	
Sex <input type="checkbox"/> M <input type="checkbox"/> F Age _____ Birthdate _____	E-mail _____
Employed by _____	Occupation _____
Business Address _____	City _____ State _____ Zip _____
Who is responsible for this account? _____	Relationship to Patient _____
Whom may we thank for referring you? _____	Relationship to Patient _____
Spouse/Parent (please circle which) Name _____	Spouse/Parent (please circle which) Birthdate _____
Spouse/Parent (please circle which) Employed by _____	Occupation _____
Business Address _____	City _____ State _____ Zip _____

Phone Numbers

Home Phone (____) _____	Cell Phone (____) _____	Cell Carrier Company (for sending texts) _____
Work Phone (____) _____	Ext _____	Spouse's Cell Phone (____) _____
IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.) Name _____		
Home Phone (____) _____	Cell Phone (____) _____	Work Phone (____) _____ Ext _____

Dental Insurance

<u>PRIMARY INSURANCE</u>	<u>SECONDARY INSURANCE</u>
Does patient have dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is patient covered by secondary insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
Subscriber's Name _____	Subscriber's Name _____
Relationship to patient _____	Relationship to patient _____
Birthdate _____ SS# _____	Birthdate _____ SS# _____
Insurance Co. _____	Insurance Co. _____
ID# _____ Phone (____) _____	ID# _____ Phone (____) _____
Names of other people covered under this plan _____	Names of other people covered under this plan _____
_____	_____

The information contained on both pages of these patient forms are accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health or insurance.

X _____ /_____/_____
If patient is a minor: Parent/Guardian's Signature Date

Dental History

Why have you come in to see us today? (e.g.: pain, checkup, etc.) _____

Former Dentist _____ Date of last dental care _____

Address _____ Date of last dental x-rays _____

Reasons for changing dentists: _____

What problems have you had with past dental treatment? _____

Please check (☑) the appropriate "Yes" or "No" to each of the following questions:

- | | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No I clench/grind my teeth during the day or while sleeping. | <input type="checkbox"/> Yes <input type="checkbox"/> No I have had periodontal treatment or a deep cleaning. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No My gums bleed while brushing or flossing. | <input type="checkbox"/> Yes <input type="checkbox"/> No I have sensitivity to hot or cold. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No I avoid brushing part of my mouth due to pain. | <input type="checkbox"/> Yes <input type="checkbox"/> No I have sensitivity to sweets. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No I have sores or growths in my mouth. | <input type="checkbox"/> Yes <input type="checkbox"/> No I have sensitivity when biting. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No I have problems eating. | <input type="checkbox"/> Yes <input type="checkbox"/> No I have a dry mouth. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No I have a clicking or popping jaw. | <input type="checkbox"/> Yes <input type="checkbox"/> No I have had orthodontics or braces. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No I have had facial or jaw injury or surgery. | <input type="checkbox"/> Yes <input type="checkbox"/> No I like my smile. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No I have loose teeth or broken fillings. | <input type="checkbox"/> Yes <input type="checkbox"/> No I want my teeth straight. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No I prefer tooth-colored fillings. | <input type="checkbox"/> Yes <input type="checkbox"/> No I want my teeth whiter. |

How many times a week do you floss? _____

How many times a week do you brush? _____

Medical History

Physician's Name _____ Date of last visit _____

Physician's Phone (_____) _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phenteramine), Pondimin (fenfluramine), and Redux (dexfenfluramine). Yes No

Please check (☑) "Yes" or "No" to indicate if you have or have had any of the following:

- | | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis, Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No HIV/AIDS |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No Jaundice |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Back Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Jaw Pain |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No Low Blood Pressure |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Nervous Problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cortisone Treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric Care |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cough, persistent or bloody | <input type="checkbox"/> Yes <input type="checkbox"/> No Radiation Treatment |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes <input type="checkbox"/> type I <input type="checkbox"/> type II | <input type="checkbox"/> Yes <input type="checkbox"/> No Respiratory Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No Scarlet Fever |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Fainting or dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of Breath |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No Sinus Trouble |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No Skin Rash |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Special Diet/Weight Loss |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis Type _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Swollen Feet or Ankles |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Problems |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No Tobacco Habit |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No Tonsillitis |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No Tumors or Growths |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcer |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No Venereal Disease |

Have you ever taken these medications?

- Yes No Blood Thinners
 Yes No Coumadin
 Yes No Warfarin
 Yes No **OSTEOPOROSIS DRUGS**
 Yes No Levoxyil
 Yes No Synthroid

Have you ever had/been diagnosed with:

- Yes No Artificial Heart Valves
 Yes No Artificial Joints:
 Hip Knee Other
 Yes No Bleeding abnormally,
 with extractions or surgery
 Yes No Blood Disease
 Yes No Congenital Heart Lesions
 Yes No Heart Murmur
 Yes No Hernia Repair
 Yes No Mitral Valve Prolapse
 Yes No **PACEMAKER**

Have you ever had any complications following dental treatment? Yes No

If yes, please describe _____

Do you have any other medical problem or medical history NOT listed on this form? Yes No

If yes, please describe _____

WOMEN:

Yes No Are you pregnant?

Due Date: _____

Yes No Are you nursing?

Yes No Talking birth control pills?

Are you allergic to:

- Yes No Aspirin
 Yes No Barbiturates
 Yes No Codeine
 Yes No Ibuprofen
 Yes No **LATEX**
 Yes No Local anesthesia
 Yes No Metals (i.e. gold, nickel, etc.)
 Yes No Penicillin

OTHERS _____

Please PRINT all medications now taking: _____

Initial medical/dental health reviewed by:

X _____ /_____/_____/ X _____ /_____/_____/

Doctor's Signature

Date

If patient is a minor: Parent/Guardian's Signature

Date

Periodic medical/dental health reviewed by:

X _____ /_____/_____/ X _____ /_____/_____/

Doctor's Signature

Date

If patient is a minor: Parent/Guardian's Signature

Date