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 _____ Drivers License # and State _____
Last Name First Name Middle Initial

Home Address_____ ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for _____ years

City _____ State _____ Zip _____

Sex ☐ M ☐ 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

PRIMARY INSURANCE

Does patient have dental insurance? ☐ Yes ☐ No

Subscriber's Name _____

Relationship to patient _____

Birthdate _____ SS# _____

Insurance Co. _____

ID# _____ Phone (____)_____

Names of other people covered under this plan _____

_____

SECONDARY INSURANCE

Is patient covered by secondary insurance? ☐ Yes ☐ No

Subscriber's Name _____

Relationship to patient _____

Birthdate _____ SS# _____

Insurance Co. _____

ID# _____ Phone (____)_____

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_____ _____/_____/_____
Patient signature: 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:

☐ Yes ☐ No I clench/grind my teeth during the day or while sleeping.
☐ Yes ☐ No My gums bleed while brushing or flossing.
☐ Yes ☐ No I avoid brushing part of my mouth due to pain.
☐ Yes ☐ No I have sores or growths in my mouth.
☐ Yes ☐ No I have problems eating.
☐ Yes ☐ No I have a clicking or popping jaw.
☐ Yes ☐ No I have had facial or jaw injury or surgery.
☐ Yes ☐ No I have loose teeth or broken fillings.
☐ Yes ☐ No I prefer tooth-colored fillings.

☐ Yes ☐ No I have had periodontal treatment or a deep cleaning.
☐ Yes ☐ No I have sensitivity to hot or cold.
☐ Yes ☐ No I have sensitivity to sweets.
☐ Yes ☐ No I have sensitivity when biting.
☐ Yes ☐ No I have a dry mouth.
☐ Yes ☐ No I have had orthodontics or braces.
☐ Yes ☐ No I like my smile.
☐ Yes ☐ No I want my teeth straight.
☐ Yes ☐ 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:

☐ Yes ☐ No Arthritis, Rheumatism
☐ Yes ☐ No Asthma
☐ Yes ☐ No Cancer
☐ Yes ☐ No Chemical Dependency
☐ Yes ☐ No Chemotherapy
☐ Yes ☐ No Cortisone Treatments
☐ Yes ☐ No Diabetes ☐ type I ☐ type II
☐ Yes ☐ No Emphysema
☐ Yes ☐ No Epilepsy
☐ Yes ☐ No Fainting or dizziness
☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Heart Problems
☐ Yes ☐ No Hemophilia
☐ Yes ☐ No Hepatitis Type _____

☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No HIV/AIDS
☐ Yes ☐ No Jaundice
☐ Yes ☐ No Kidney Disease
☐ Yes ☐ No Liver Disease
☐ Yes ☐ No Radiation Treatment
☐ Yes ☐ No Respiratory Disease
☐ Yes ☐ No Stroke
☐ Yes ☐ No Thyroid Problems
☐ Yes ☐ No Tobacco Habit
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Tumors or Growths
☐ Yes ☐ No Ulcers

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 Taking birth control pills?

Have you ever taken these medications?

☐ Yes ☐ No Blood Thinners
☐ Yes ☐ No Coumadin/Warfarin
☐ Yes ☐ No Levoxyl/Syntrhoid
☐ Yes ☐ No **OSTEOPOROSIS DRUGS**

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 **PACEMAKER**

Are you allergic to:

☐ Yes ☐ No Aspirin/Ibuprofen
☐ Yes ☐ No Barbiturates
☐ Yes ☐ No Codeine
☐ Yes ☐ No **LATEX**
☐ Yes ☐ No Metals (i.e. gold, nickel, etc.)
☐ Yes ☐ No Penicillin

OTHER ALERGIES_____

_____

Please PRINT all medications now taking:_____

_____

Initial medical/dental health reviewed by:

X_____ _____/_____/_____ X_____ _____/_____/_____

Doctor's Signature Date Patient signature: Parent/Guardian's Signature Date