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PATIENT INFORMATION

Name: _____ ☐ Married ☐ Single ☐ Minor ☐ Male ☐ Female
LAST FIRST M

Address: _____
STREET APT # CITY STATE ZIP

Birth Date: _____ Age: _____ SS#_____

Telephone: _____ Cell: _____ Email: _____

Place of Employment: _____ Phone: _____

If Full Time Student, School Name: _____

REFERRAL INFROMATION

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative
☐ Dental office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice _____

INSURANCE INFORMATION

Primary

Name of Insured: _____ Is the insured a patient? ☐ Yes ☐ No

Insured's Birth Date_____ SS # _____ Group # _____

Insured's Address _____

Insured's Employer's Name _____

Address _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name and Address _____

METHOD OF PAYMENT (Please check all that apply)

☐ I do not have dental insurance and I agree to pay for any and all treatment either:
☐ Prior to Treatment ☐ The Day Services are provided

☐ I have dental insurance and would like to have this office file insurance claims for me. I understand that all insurance co-pay estimates are due the day of services

AUTHORIZATION (All Patients or Guardians must sign)

I authorize the dentist to perform diagnostic procedures and treatments as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits or credit information. I authorize payment of insurance benefits directly to the dentist group, otherwise payable to me.

_____ Date_____
Patient's or Guardian's Signature

MEDICAL HISTORY

Are you under a physician's care now? Who? Why? _____ Phone_____
Have you ever been hospitalized or had a major operation? Discuss_____
Have you ever had a serious injury to your head or neck? Discuss _____
Are you taking any medications, pills, or drugs? Discuss _____
Are you allergic to any medications or substances? Please check box below
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other
Women (please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking Oral Contraceptives

*if yes to any of the starred conditions, please call prior to your appointment…Premedication may be required

	Y	N
Heart Trouble/Disease	☐	☐
Heart Murmur	☐	☐
Irregular Heart Beat	☐	☐
Angina/Chest Pain	☐	☐
Heart Attack	☐	☐
Congenital Heart Disorder	☐	☐
Mitral Valve Prolapse*	☐	☐
Scarlet Fever	☐	☐
Rheumatic Fever*	☐	☐
Artificial Heart Valve*	☐	☐
Heart Pace Maker	☐	☐
Heart Surgery*	☐	☐
High Blood Pressure	☐	☐
Blood Disease	☐	☐
Bruise Easily	☐	☐
Anemia	☐	☐
Excessive Bleeding	☐	☐

	Y	N
Sickle Cell	☐	☐
Glaucoma	☐	☐
Tumors or Growths	☐	☐
Nervousness	☐	☐
Psychiatric	☐	☐
Alzheimer's Disease	☐	☐
Hemophilia	☐	☐
Recent Blood Transfusion	☐	☐
Swelling of Limbs	☐	☐
Lung Disease	☐	☐
Breathing Problem	☐	☐
Shortness of Breath	☐	☐
Frequent Cough	☐	☐
Hay Fever	☐	☐
Sinus Trouble	☐	☐
Asthma	☐	☐
Emphysema	☐	☐

	Y	N
Tuberculosis	☐	☐
Cancer	☐	☐
X-Ray Treatments	☐	☐
Chemotherapy	☐	☐
Stomach/Intestinal Disease	☐	☐
Ulcers	☐	☐
Recent Weight Loss	☐	☐
Stroke	☐	☐
Convulsions	☐	☐
Epilepsy or Seizures	☐	☐
Fainting or Dizziness	☐	☐
Allergies (Pollen/Dust)	☐	☐
Diabetes	☐	☐
Excessive Thirst	☐	☐
Hypoglycemia	☐	☐
Liver Disease	☐	☐
Hepatitis A (infectious)	☐	☐

	Y	N
Hepatitis B or C	☐	☐
Yellow Jaundice	☐	☐
Kidney Problems	☐	☐
Renal Dialysis	☐	☐
Thyroid Disease	☐	☐
Arthritis/Gout	☐	☐
Rheumatism	☐	☐
Pain in Jaw Joint	☐	☐
Cortisone/Steroid Therapy	☐	☐
Artificial Joint*	☐	☐
Organ Transplant*	☐	☐
AIDS	☐	☐
HIV Positive	☐	☐
Drug Addiction	☐	☐
Cold Sore	☐	☐
Fever Blister	☐	☐
Herpes	☐	☐

Have you ever had any illness not checked above? ☐ Yes ☐ No Discuss_____
Number of sodas or sweet drinks per day? _____ Do you smoke? ☐ Yes ☐ No How many packs a day? _____
Do you use any other form of tobacco? ☐ Yes ☐ No What kind? _____
Do you wish to talk to the dentist privately about any problems? _____
To the best of my knowledge, all of the proceeding answers are correct. If I have any changes in health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.
X_____ (Patient's Signature) Date_____
Reviewed by Doctor_____ Date_____

DENTAL HISTORY

Are any family members current patients?
Name of previous dentist_____
Date of last dental visit _____
How long since last cleaning? _____
Reason for changing? _____
Describe your current dental problem _____ _____

APPREHENSION

	Y	N
Do you experience any fear of having dental treatment performed?	Y	N
Anything specific? _____		
Do you dread the numbing after effects?	Y	N
Have you ever hand any unpleasant dental experiences?	Y	N
Have you ever received laughing gas?	Y	N
Have you ever received any other kind of sedation for treatment?	Y	N
Do you feel you need any help overcoming fear?	Y	N

TEETH PROBLEMS

	Y	N
Are your teeth sensitive to hot, cold, sweet, or pressure?	Y	N
Does food regularly wedge between certain teeth?	Y	N
Do you have any areas that hard to floss?	Y	N

YOUR SMILE

	Y	N
Do you think you have a pretty smile?	Y	N
Are your teeth crooked?	Y	N
Have you had any cosmetic dentistry?	Y	N
Do you have any fillings or blemishes on your teeth that look bad?	Y	N
Would you like to have whiter teeth?	Y	N

Is there anything that you feel could make your smile look better?

HEADACHES AND FACIAL PAIN

	Y	N
Do you have frequent headaches?	Y	N
Do you experience popping or clicking upon opening or closing your mouth?	Y	N
Do your jaw/facial muscles ever get tired or sore after chewing, sleeping, stress, etc?	Y	N

GUM PROBLEMS

	Y	N
Do your gums ever bleed when you brush or floss?	Y	N
Have your gums receded or pulled away from your teeth?	Y	N
Do you have bad breath or bad tastes?	Y	N