Welcome	***Thank you for selecting our dental healthcare team!*** ***We will strive to provide you with the best possible dental care. To help us meet all your dental needs, please fill out this form completely. If you have any questions or need assistance, please ask us - we will be happy to help.***

Patient Information (Confidential)

Date ________________________

Name ____________________________________ Referred By _________________________________

Residence Address ____________________________ City ________________ Zip ____________

Mailing Address (if different) _______________________________ E-mail _____________________

Phone: Residence _____________ Work Phone ____________ Ext. ______ Cell _______________

Soc. Sec. # ______________________________ Birthdate __________________

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Patient's Employer __________________________ Present Position ____________________________

Employer's Address ____ Zip _____________

How Long Have You Worked for this Employer? ____

Spouse's Name _______________ Soc. Sec. # _______________ Spouse's Birthdate __________

Spouse's Employer _______________________ Spouse's Present Position ________________

Spouse's Employer's Address ____ Zip ___________

Spouse's Work Phone ________________ How Long Has He/She Worked For This Employer? ______

Other Than Spouse, Person to Contact in Case of Emergency _______________ Phone ___________

Person Responsible for Account: ☐Self ☐Spouse ☐ Parent ☐Other

Does Responsible Person Have a Checking Account? ☐Yes ☐No Credit Card? ☐Yes ☐ No

Insurance Information

I have dental insurance: ☐Yes ☐No If you have insurance, let us copy your card. Without your card or the information on your card, we cannot file your insurance. Please review the attached blue sheet, "How We Help With Your Dental Insurance".

Appointment Information

Please reserve appointments only at a time you know you will be available. If you find it necessary to change an appointment, please give us at least one *full* business day's notice. Our usual business days are Monday, Tuesday, Wednesday, and Friday. We reserve the right to charge for appointments cancelled, changed, or failed with less than one *full* business day's notice. The usual charge is $20 for each 10 minutes of reserved time.

I have read, understand and agree to the above "***Appointment Information***". Initials Please ________

Patient Medical History *(Please mark each item "Yes" or "No".)*

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Name of Medical Doctor ______________________________ Date of Last Exam ______________

Reason for this Dental Appointment ____

1. Are you under medical treatment at the present time?. □ Yes □ No
2. To what medications are you allergic?

____

3. List Hospitalizations for Serious Illness or Surgeries

____

____

4. List Medications (prescription and non-prescriptions) That you take regularly

____

____

	Yes	No
5. Do you use tobacco in any form?	□	□
6. Do you use cocaine, or other drugs?	□	□
7. How many alcoholic drinks per week do you have?		
8. Have you ever taken any bisphosphonate drugs (Actonel, Boniva, Fosamax, etc. ………..		
9. Women Only:	□	□
a) Are you pregnant or do you think you may be pregnant?		
b) Are you nursing?	□	□
c) Are you taking birth control pills? ….......	□	□
_______________________________________	□	□

Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
Heart Disease/Trouble.......	□	□	Fainting/Seizures..............	□	□	Liver Disease...................	□	□
Heart Attack..................	□	□	Epilepsy or Convulsions.....	□	□	Hepatitis/Jaundice............	□	□
Heart Surgery..................	□	□	Respiratory Problems.........	□	□	AIDS or HIV Infection........	□	□
Swollen Ankles...............	□	□	Asthma............................	□	□	Arthritis............................	□	□
High Blood Pressure.........	□	□	Tuberculosis.....................	□	□	Joint Replacement/Implant	□	□
Low Blood Pressure..........	□	□	Hay Fever/Allergies...........	□	□	Glaucoma........................	□	□
Angina............................	□	□	Cancer.............................	□	□	Thyroid Problem..............	□	□
Cardiac Pacemaker..........	□	□	Leukemia..........................	□	□	Kidney Disease................	□	□
Easily Winded.................	□	□	Recent Weight Loss...........	□	□	Diabetes..........................	□	□
Chest Pains.....................	□	□	Radiation Therapy.............	□	□	Blood Clotting Disorders ...	□	□
Stroke.............................	□	□	Stomach Trouble/Ulcers…..	□	□	Other.............................	□	□

Patient Dental History

	Yes	No
1. Do your gums bleed when you brush or floss? ...	□	□
2. Are your teeth sensitive to hot or cold liquids/foods?	□	□
3. Are your teeth sensitive to sweet liquids/foods?	□	□
4. Do you have or feel pain in any of your teeth?	□	□
5. Do you have sores or lumps in or near your mouth?	□	□
6. Have you had any head, neck or jaw injuries?	□	□
7. Have you ever experienced any of the following problems in your jaw?		
a) Clicking ?...	□	□
b) Pain (joint, ear, side of face)?	□	□
c) Difficulty in opening or closing?	□	□
d) Difficulty in chewing?	□	□
8. Do you have frequent headaches?	□	□

Why did you leave your last dental office? __________

____

Date of last dental visit:

	Yes	No
9. Do any teeth hurt to bite hard foods? .	□	□
10. Does food pack between your teeth? .	□	□
11. Have you ever had any prolonged bleeding following an extraction?..............	□	□
12. Have you ever had braces?	□	□
13. Do you want information on preventing tooth decay and gum disease?.	□	□
14. Does dental treatment make you nervous?..	□	□
15. Are you unhappy with your smile?	□	□
16. Do you want your teeth whitened ?.....	□	□

17. My toothbrush is ____Soft ____ Med ____ Hard.......

18. How often do you brush? ___________

19. How many times each week do you floss? ____________________________

Authorization and Release

I certify that I have read and understand the above information and to the best of my knowledge have accurately answered all questions. 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 during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company or dental group benefits to pay directly to the dentist 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 in excess of my insurance payments. I will report any changes in my health or medicines, or insurance coverage at the next appointment.

Signature: ______________________________ Date: ____________ Dr. Initials ___________