WELCOME

Thank you for trusting us with your health care. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to call us.

PATIENT INFORMATION

Date _____ SS/HIC/Patient ID # _____

Patient Name _____ (Last name) _____ (First name) _____ (Middle Initial)

Address _____ _____ (City) _____ (State) _____ (Zip)

Email _____ Sex ◯ M ◯ F Birthdate _____ (Month) _____ (Day) _____ (Year) Age _____

◯ Married ◯ Widowed ◯ Single ◯ Minor ◯ Separated ◯ Divorced ◯ Partnered for _____ years

Occupation _____ _____ (Employer) _____ (Address) _____ (Phone #)

Spouse's Name _____ Birthdate _____ (Month) _____ (Day) _____ (Year)

SS# _____ Spouse's Employer _____

Who may we thank for referring you? _____

PHONE NUMBERS

Phone # _____ Work # _____ Ext _____ Alternate # _____

Spouse's Work # _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Please specify someone who does not live in your household)

Name _____ Relationship _____ Phone # _____ Work # _____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____ Group # _____

Is Patient covered by additional insurance? ◯ Yes ◯ No

Subscriber's name _____

Birthdate _____ (Month) _____ (Day) _____ (Year) SS# _____

Relationship to Patient _____

Insurance Co. _____ Group # _____

ASSIGNMENT AND RELEASE I certify that I, and/or my dependant(s), have insurance coverage with _____ (Name of insurance company(ies)) and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian, or Personal Representative

_____
Print name of Patient, Parent, Guardian, or Personal Representative

_____ (Date) _____ (Relationship to Patient)

DENTAL HISTORY

Reason for Today's visit _____ Date of last dental visit _____ Date of last dental X-rays _____

Former Dentist _____ City/State _____

Place a mark on "yes" or "no" to indicate if you have had any of the following

Yes ◯	No ◯	Bad breath	Yes ◯	No ◯	Food collection between teeth	Yes ◯	No ◯	Orthodontic treatment
Yes ◯	No ◯	Bleeding gums	Yes ◯	No ◯	Foreign objects	Yes ◯	No ◯	Pain around ear
Yes ◯	No ◯	Blisters on lips or mouth	Yes ◯	No ◯	Grinding teeth	Yes ◯	No ◯	Periodontal treatment
Yes ◯	No ◯	Burning sensation on tongue	Yes ◯	No ◯	Gums swollen or tender	Yes ◯	No ◯	Sensitivity to cold
Yes ◯	No ◯	Chew on one side of mouth	Yes ◯	No ◯	Jaw pain or tiredness	Yes ◯	No ◯	Sensitivity to heat
Yes ◯	No ◯	Cigarette, pipe or cigar smoking	Yes ◯	No ◯	Lip or cheek biting	Yes ◯	No ◯	Sensitivity when biting
Yes ◯	No ◯	Clicking or popping jaw	Yes ◯	No ◯	Loose teeth or broken fillings	Yes ◯	No ◯	Sores or growths in mouth
Yes ◯	No ◯	Dry mouth	Yes ◯	No ◯	Mouth breathing	How often do you floss?		
Yes ◯	No ◯	Fingernail biting	Yes ◯	No ◯	Mouth pain, brushing	How often do you brush?		

HEALTH HISTORY

Physician's name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didro, Boniva Yes ◯ No ◯

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 phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes ◯ No ◯

Place a mark on "yes" or "no" to indicate if you have had any of the following

Yes ◯	No ◯	AIDS/HIV	Yes ◯	No ◯	Do you wear contact lenses?	Yes ◯	No ◯	Radiation Therapy
Yes ◯	No ◯	Anemia	Yes ◯	No ◯	Epilepsy	Yes ◯	No ◯	Respiratory Disease
Yes ◯	No ◯	Arthritis, Rheumatism	Yes ◯	No ◯	Fainting or Dizziness	Yes ◯	No ◯	Rheumatic Fever
Yes ◯	No ◯	Artificial Heart Valves	Yes ◯	No ◯	Glaucoma	Yes ◯	No ◯	Scarlet Fever
Yes ◯	No ◯	Artificial Joints	Yes ◯	No ◯	Headaches	Yes ◯	No ◯	Shortness of Breath
Yes ◯	No ◯	Asthma	Yes ◯	No ◯	Heart Murmur	Yes ◯	No ◯	Sinus Trouble
Yes ◯	No ◯	Back Problems	Yes ◯	No ◯	Heart Problems	Yes ◯	No ◯	Skin Rash
Yes ◯	No ◯	Bleeding abnormally with extractions or surgery	Yes ◯	No ◯	Hepatitis Type ____	Yes ◯	No ◯	Special Diet
			Yes ◯	No ◯	Herpes	Yes ◯	No ◯	Stroke
Yes ◯	No ◯	Blood Disease	Yes ◯	No ◯	High Blood Pressure	Yes ◯	No ◯	Swollen Feet or Ankles
Yes ◯	No ◯	Cancer	Yes ◯	No ◯	Jaundice	Yes ◯	No ◯	Swollen Neck Glands
Yes ◯	No ◯	Chemical Dependency	Yes ◯	No ◯	Jaw Pain	Yes ◯	No ◯	Thyroid Problems
Yes ◯	No ◯	Chemotherapy	Yes ◯	No ◯	Kidney Disease	Yes ◯	No ◯	Tonsillitis
Yes ◯	No ◯	Circulatory Problems	Yes ◯	No ◯	Liver Disease	Yes ◯	No ◯	Tuberculosis
Yes ◯	No ◯	Congenital Heart Lesions	Yes ◯	No ◯	Low Blood Pressure	Yes ◯	No ◯	Tumor or growth on head or neck
Yes ◯	No ◯	Cortisone Treatments	Yes ◯	No ◯	Mitral Valve Prolapse			
Yes ◯	No ◯	Cough, persistent or bloody	Yes ◯	No ◯	Nervous Problems	Yes ◯	No ◯	Ulcer
Yes ◯	No ◯	Diabetes	Yes ◯	No ◯	Pacemaker	Yes ◯	No ◯	Venereal Disease
Yes ◯	No ◯	Emphysema	Yes ◯	No ◯	Psychiatric Care	Yes ◯	No ◯	Weight Loss, unexplained
Women Only								
Yes ◯	No ◯	Are you pregnant? Due Date: _____	Yes ◯	No ◯	Taking birth control pills?	Yes ◯	No ◯	Are you nursing?

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____ _____
Medication Diagnosis

_____ _____
Medication Diagnosis

_____ _____
Medication Diagnosis

Pharmacy _____ _____
Name Phone #

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (sleeping pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

UPDATES (to be filled in at future appointments)

Has there been any change in your health since your last dental appoinment? _____

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appoinment? _____

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____