



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 to maintain your dental health.

PATIENT INFORMATION

Name (Last Name) (First Name) (Middle Initial) Social Security #

Address City State Zip

Home/Main Phone Cell/Other Phone Email

Sex M F Age Birthdate Single Married Widowed Separated Divorced

Patient employed by Occupation

Business Address Business Phone

Business Email Who may we thank for referring you?

Notify in case of emergency (name) Home/Main Phone

Cell/Other Phone Business Phone Email

PRIMARY INSURANCE

Person Responsible For Account (Last Name) (First Name) (Middle Initial)

Relation to Patient Birthdate Social Security #

Address (if different from patient) City State Zip

Home/Main Phone Cell/Other Phone Email

Person Responsible employed by Occupation

Business Address Business Phone

Business Email Insurance Company

Insurance Phone Insurance Email

Contract # Group # Subscriber #

Name of other dependents under this plan

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Y N

Subscriber Name Relation to Patient Birthdate

Address (if different from patient) City State Zip

Home/Main Phone Cell/Other Phone Email

Person Responsible employed by Occupation

Business Address Business Phone

Business Email Insurance Company

Insurance Phone Insurance Email

Contract # Group # Subscriber #

Name of other dependents under this plan

Please complete both sides of this form before returning it to our team.

DENTAL HISTORY

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist's Name _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care appointment _____ Date of last dental x-rays _____

Check (✓) Y (yes) or N (no) if you have had problems with any of the following:

___ Y ___ N Bad breath

___ Y ___ N Food collection between teeth

___ Y ___ N Periodontal treatment

___ Y ___ N Sensitivity to sweets

___ Y ___ N Bleeding gums

___ Y ___ N Grinding or clenching teeth

___ Y ___ N Sensitivity to cold

___ Y ___ N Sensitivity when biting

___ Y ___ N Clicking or popping jaw

___ Y ___ N Loose teeth or broken fillings

___ Y ___ N Sensitivity to hot

___ Y ___ N Sores or growths in mouth

How often do you brush? _____

How often do you floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ___ Y ___ N

Other information about your dental health or previous treatment?

MEDICAL HISTORY

Physician's Name _____ Phone _____

Date of last visit _____ Have you had any serious illness or operations? ___ Y ___ N

If yes, please describe _____

Are you currently under physician care? ___ Y ___ N If yes, please describe _____

Have you ever had a blood transfusion? ___ Y ___ N If yes, please give approximate date _____

Have you ever taken Fen-Phen/Redux? ___ Y ___ N Have you ever used a bisphosphonate medication (i.e. Fosamax, Actonel, etc.)? ___ Y ___ N

Women: Are you pregnant? ___ Y ___ N Are you nursing? ___ Y ___ N Are you taking birth control pills? ___ Y ___ N

Check (✓) Y (yes) or N (no) if you have had any of the following:

___ Y ___ N AIDS/HIV Positive

___ Y ___ N Anaphylaxis

___ Y ___ N Anemia

___ Y ___ N Arthritis, Rheumatism

___ Y ___ N Artificial heart valves

___ Y ___ N Artificial joints

___ Y ___ N Asthma

___ Y ___ N Atopic (allergy prone)

___ Y ___ N Back problems

___ Y ___ N Blood disease

___ Y ___ N Cancer

___ Y ___ N Chemical dependency

___ Y ___ N Chemotherapy

___ Y ___ N Circulatory problems

___ Y ___ N Cortisone treatments

___ Y ___ N Cough, persistent

___ Y ___ N Cough up blood

___ Y ___ N Diabetes

___ Y ___ N Epilepsy

___ Y ___ N Fainting

___ Y ___ N Food allergies

___ Y ___ N Glaucoma

___ Y ___ N Headaches

___ Y ___ N Heart murmur

___ Y ___ N Heart problems

___ Y ___ N Hemophilia/
Abnormal bleeding

___ Y ___ N Herpes

___ Y ___ N Hepatitis

___ Y ___ N High blood pressure

___ Y ___ N Jaw pain

___ Y ___ N Kidney disease

___ Y ___ N _____
or malfunction

___ Y ___ N Liver disease

___ Y ___ N Material allergies

(latex, wool, metal, chemicals)

___ Y ___ N Mitral valve prolapse

___ Y ___ N Nervous problems

___ Y ___ N Pacemaker/
Heart Surgery

___ Y ___ N Psychiatric care

___ Y ___ N Rapid weight loss/gain

___ Y ___ N Radiation treatment

___ Y ___ N Respiratory disease

___ Y ___ N Rheumatic/Scarlet fever

___ Y ___ N Shingles

___ Y ___ N Shortness of breath

___ Y ___ N Skin rash

___ Y ___ N Spina bifida

___ Y ___ N Stroke

___ Y ___ N Surgical implant

___ Y ___ N Swelling of feet

or ankles

___ Y ___ N Thyroid disease

or malfunction

___ Y ___ N Tobacco habit

___ Y ___ N Tonsillitis

___ Y ___ N Tuberculosis

___ Y ___ N Ulcer/Colitis

___ Y ___ N Venereal disease

Is patient currently taking any medications? ___ Y ___ N If yes, list all: _____

Does patient have drug allergies? ___ Y ___ N If yes, list all: _____

AUTHORIZATION

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine the appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. · I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. · I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not they are paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved. 2 of 2