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 healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us – we will be happy to help.

Patient Information (Confidental)

Date _____

Name _____ Birthdate _____ SS # _____ (copy of driver's license if no SS # given)

Home Phone _____ Cell Phone _____ E-mail _____

We confirm appointments via text message or e-mail. Will this work for you? Please check ❑ Text ❑ E-mail

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Patient's or Parent/Guardian Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parents's Name _____ Employer _____ Work Phone _____

If Patient is a Student, Name of School/College _____ City _____ State _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

SS # _____ Birthdate _____ Employer _____

Work Phone _____ Is this person currently a patient in our office? ❑ Yes ❑ No

Insurance Information (Please Present ID Card)

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS # _____ Phone Number _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ ID # _____ Group # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

Insurance Co. Phone _____ How much is your deductible? _____ Max Annual Benefit? _____

Method of Payment

We will gladly file all dental claims for your dental treatment. However, we are not party to any insurance program or contract. Because benefits differ for each insurance plan, we are unable to quote the exact amount your insurance will pay. Any balance is your responsibility whether your insurance company pays for your treatment or not. It is also your responsibility to inform us of any changes with your insurance.

PATIENT MEDICAL HISTORY

Patient Name: _____ Date: _____

Medical physician: _____ Office phone: _____ Date of last exam: _____

Although dental professionals primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dental services you will receive. Thank you for answering the following questions.

	Yes	No
1. Are you currently under medical treatment?	❑	❑
2. Have you ever been hospitalized for any surgical operation or serious illness?	❑	❑
3. Are you taking any medication(s), including non-prescription medicine? Please list: _____	❑	❑
4. Are you taking Blood Thinners or Bisphosphates? _____	❑	❑
5. Do you use tobacco products?	❑	❑
6. Are you wearing contact lenses?	❑	❑
7. Are you allergic to or have you had any reactions to the following? (please check all that apply) ❑ Local anesthetics (e.g., novocaine) ❑ Penicillin or other antibiotics ❑ Sulfa Drugs ❑ Sedatives ❑ Metal ❑ Acrylic ❑ Aspirin ❑ Latex ❑ Codeine Other:_____	❑	❑
8. Women only:		
Are you pregnant or think you may be pregnant?	❑	❑
Are you nursing?	❑	❑
Are you taking birth control pills?	❑	❑

Do you have or have you had any of the following

	Yes	No		Yes	No		Yes	No
AIDS/HIV Positive	❑	❑	Emphysema	❑	❑	Low Blood Pressure	❑	❑
Alzheimer's Disease	❑	❑	Epilepsy or Seizures	❑	❑	Mitral Valve Prolapse	❑	❑
Anemia	❑	❑	Excessive Bleeding	❑	❑	Pain in Jaw Joint	❑	❑
Angina	❑	❑	Fainting Spells/Dizziness	❑	❑	Psychiatric Care	❑	❑
Arthritis/Gout	❑	❑	Frequent Headaches	❑	❑	Radiation Treatments	❑	❑
Artificial Heart Valve	❑	❑	Glaucoma	❑	❑	Recent Weight Loss	❑	❑
Artificial Joint	❑	❑	Heart Attack/Failure	❑	❑	Rheumatic Fever	❑	❑
Asthma	❑	❑	Heart Murmur	❑	❑	Sinus Trouble	❑	❑
Blood Disease	❑	❑	Heart Pace Maker	❑	❑	Stomach/Intestinal Disease	❑	❑
Breathing Problem	❑	❑	Heart Trouble/Disease	❑	❑	Stroke	❑	❑
Bruises Easily	❑	❑	Hepatitis A	❑	❑	Swelling of Limbs	❑	❑
Cancer	❑	❑	Hepatitis B or C	❑	❑	Thyroid Disease	❑	❑
Chemotherapy	❑	❑	Herpes	❑	❑	Tonsillitis	❑	❑
Chest Pain	❑	❑	High Blood Pressure	❑	❑	Tuberculosis	❑	❑
Cold Sores/Fever Blisters	❑	❑	Hypoglycemia	❑	❑	Tumors or Growths	❑	❑
Congenital Heart Disorder	❑	❑	Irregular Heartbeat	❑	❑	Ulcers	❑	❑
Convulsions	❑	❑	Kidney Problems	❑	❑	Venereal Disease	❑	❑
Cortisone Medicine	❑	❑	Leukemia	❑	❑	Yellow Jaundice	❑	❑
Diabetes	❑	❑	Liver Disease	❑	❑			

Have you ever had any serious illness not listed above? ❑ Yes ❑ No If yes, please explain:

_____

_____

_____

PATIENT DENTAL HISTORY

	Yes	No
1. Do your gums bleed while brushing or flossing?	❑	❑
2. Are your teeth sensitive to hot or cold liquids/foods?	❑	❑
3. Are your teeth sensitive to sweet/sour liquids/foods?	❑	❑
4. Do you feel pain with any of your teeth?	❑	❑
5. Do you have any sores or lumps in or near your mouth?	❑	❑
6. Have you had any head, neck or jaw injuries?	❑	❑
7. Have you ever had any difficult extractions in the past with prolonged bleeding?	❑	❑
8. Do you clench or grind your teeth?	❑	❑
9. Have you had any orthodontic work?	❑	❑
10. Have you ever experienced any of the following problems in your jaw?	❑	❑
a) Clicking?	❑	❑
b) Pain (joint, ear, side of face)?	❑	❑
c) Difficulty opening, closing or chewing?	❑	❑
11. Have you ever had instructions on the proper care of your teeth and gums?	❑	❑
12. Are you interested in receiving information about porcelain veneers or teeth whitening?	❑	❑
13. Do you like your smile?	❑	❑

To the best of my knowledge, the questions on these forms have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian: _____ Date: _____