DATE: _____ / _____ / _____

PATIENT INFORMATION

PATIENT'S NAME: _____ SEX: M / F AGE: _____ BIRTHDATE: _____ / _____ / _____

ADDRESS: _____ HOME PHONE: _____ CELL PHONE: _____

CITY: _____ STATE: _____ ZIP: _____ EMAIL ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____ Add Email to Newsletter? ☐ YES ☐ NO

CHECK APPROPRIATE BOX: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

(IF MINOR) PARENT OR GUARDIAN'S NAME: _____

BUSINESS ADDRESS: _____ CITY: _____STATE: _____ ZIP: _____

SPOUSE'S NAME: _____ EMPLOYER: _____ WORK PHONE: _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE: _____ CITY: _____ STATE: _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY: _____ PHONE: _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUT OFFICE? _____

RESPONSIBLE PARTY

PERSON RESPONSIBLE: _____SS#: _____ Driver's Lic.#: _____

ADDRESS: _____ CITY: _____ HOME PHONE: _____

STATE: _____ ZIP: _____ EMPLOYER: _____ WORK PHONE: _____

RELATIONSIP TO PATIENT: _____ IS THIS PERSON CURRENTLY A PATIENT IN OUR OF ☐ YES ☐ NO

INSURANCE INFORMATION

PRIMARY

NAME OF INSURED: _____ RELATIONSHIP TO PATIENT: _____

BIRTHDATE: _____ SOCIAL SECURITY NUMBER: _____ DATE EMPLOYED: _____

NAME OF EMPLOYER: _____ WORK PHONE: _____

ADDRESS OF EMPLOYER: _____ CITY: _____ STATE: _____ ZIP: _____

INSURANCE COMPANY: _____ GROUP3: _____ UNION OR LOCAL #: _____

INS. CO. ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE ☐ YES ☐ NO IF YES, COMPLETE THE SECONDARY INFORMATION

SECONDARY

NAME OF INSURED: _____ RELATIONSHIP TO PATIENT: _____

BIRTHDATE: _____ SOCIAL SECURITY NUMBER: _____ DATE EMPLOYED: _____

NAME OF EMPLOYER: _____ WORK PHONE: _____

ADDRESS OF EMPLOYER: _____ CITY: _____ STATE: _____ ZIP: _____

INSURANCE COMPANY: _____ GROUP3: _____ UNION OR LOCAL #: _____

INS. CO. ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to _____ 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that, when appropriate, credit bureau reports may be obtained.

PATIENT MEDICAL HISTORY

Patient's Physician _____ Office Phone _____ Date of Last Exam _____

PATIENT

	YES	NO
1. Are you under medical treatment now?	☐	☐
If so, for what? _____		
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
What for? _____		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
4. Have you ever been advised to take medication prior to dental visits?	☐	☐
If so, what? _____		
5. Have you seen a Dental Specialist for any reason?	☐	☐
Reason? _____		
6. Do you use tobacco (smoking or chewing)?	☐	☐
7. Have you taken diet medication (Fen-Phen)	☐	☐

8. Are you allergic to or have you had any reactions to the following?

YES	NO		YES	NO	
☐	☐	Local anesthetics	☐	☐	Codeine/Pain Medicine
☐	☐	Penicillin or other antibiotics	☐	☐	Aspirin
☐	☐	Sulfa Drugs	☐	☐	Metals
☐	☐	Latex Gloves	☐	☐	Other: _____

8. WOMEN ONLY:

	YES	NO
a) Are you pregnant or think you may be?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

YES	NO		YES	NO		YES	NO	
☐	☐	ADD	☐	☐	Fainting / Seizures	☐	☐	Mitral Valve Prolapse
☐	☐	AIDS / ARC / HIV Infection	☐	☐	Epilepsy / Convulsions	☐	☐	Prosthesis Heart Valve
☐	☐	Allergies / Hay fever	☐	☐	Glaucoma	☐	☐	Psychiatric Care
☐	☐	Anemia	☐	☐	Hearing Loss	☐	☐	Recent Weight Loss
☐	☐	Arthritis / Rheumatism	☐	☐	Heart Disease	☐	☐	Respiratory Problems
☐	☐	Artificial Joints	☐	☐	Heart Murmur	☐	☐	Rheumatic Fever
☐	☐	Bleeding Problems	☐	☐	Heart Surgery	☐	☐	Sexually Transmitted Disease
☐	☐	Cancer	☐	☐	High Blood Pressure	☐	☐	Sinus Trouble
☐	☐	Cardiac Pacemaker	☐	☐	Irregular Heart Beat	☐	☐	Stomach Ulcers
☐	☐	Chemo / Radiation Therapy	☐	☐	Jaundice	☐	☐	Stroke
☐	☐	Congenital Heart Disease	☐	☐	Kidney Disease	☐	☐	Surgical Pins or Plates
☐	☐	Diabetes	☐	☐	Leukemia	☐	☐	Thyroid Condition
☐	☐	Drug Addiction	☐	☐	Liver Disease	☐	☐	Tuberculosis
☐	☐	Emphysema	☐	☐	Low Blood Pressure			
☐	☐	Hepatitis - Type? _____	☐	☐	Heart Attack - When? _____			

MEDICAL ALERTS: _____

Comments: _____

Signature of Dentist: _____ Date: _____

PATIENT DENTAL HISTORY

	YES	NO
1. Do you have a specific dental problem?	☐	☐
Describe _____		
2. Do you have dental examinations on a routine basis?	☐	☐
Describe _____		
3. Would you describe your present dental health as good?	☐	☐
4. Do you think you have active decay or gum disease?	☐	☐
5. Do your gums ever bleed?	☐	☐
Discuss _____		
6. Do you brush and floss on a routine basis?	☐	☐
Discuss _____		
7. Do you feel nervous about having dental treatment?	☐	☐
8. Have you ever had a bad experience in a dental office?	☐	☐
Describe _____		
9. Do you want to keep your remaining teeth?	☐	☐
10. Name of previous dentist (optional) _____		
11. Do you like your smile? (If not, why?)	☐	☐
_____	☐	☐
12. Do your gums bleed while brushing or flossing?		
13. Are your teeth sensitive to hot or cold liquids / food?	☐	☐
14. Are your teeth sensitive to sweet or sour liquids / food?	☐	☐
15. Do you feel pain to any of your teeth?	☐	☐
16. Do you have any sores of lumps in or near your mouth?	☐	☐
17. Have you had any head, neck or jaw injuries?	☐	☐
18. Do you have frequent headaches?	☐	☐
19. Do you clench or grind your teeth?	☐	☐
20. Do you bit your lips or cheeks frequently?	☐	☐
21. Have you ever experienced any of the following problems in your jaw?	☐	☐
a) Clicking or popping?		
b) Pain (joint, ear or side of face)?	☐	☐
c) Difficulty I opening or closing?	☐	☐
d) Difficulty in chewing	☐	☐

I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct.
THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INADEQUATE INFORMATION NOT DISCLOSED.

Patient (Parent of Guardian) Signature _____ Date: _____