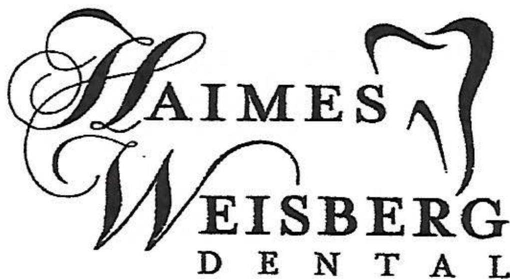

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Soc. Sec. #__________
Date__________
Home Phone__________

Patient Information (CONFIDENTIAL)

Name__________ Birthdate__________ Cell Phone__________
Address__________ City__________ State_____ Zip_____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated E-mail__________
Patient's or Parent's Employer__________ Work Phone__________
Business Address__________ City__________ State_____ Zip_____
Spouse or Parent'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__________

Patient Medical & Dental History

Physician__________ Office Phone__________ Date of Last Exam__________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐

If yes, what medication(s) are you taking?__________

	Yes	No
4. Are you allergic to or have had any reactions to the following?		
Local Anesthetics (eg. novacaine)	☐	☐
__________	☐	☐
Penicillin or other Antibiotics_____	☐	☐
Any Metals_____	☐	☐
Other Allergies_____	☐	☐
5. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you taking birth control pills?	☐	☐

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Problems	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Stroke	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Hay Fever / Allergies	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Tuberculosis	☐	☐
Fainting / Seizures	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Asthma	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Low Blood Pressure	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Epilepsy / Convulsions	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Leukemia	☐	☐	Joint Replacement or Implant	☐	☐	Respiratory Problems	☐	☐
Diabetes	☐	☐	Hepatitis / Jaundice	☐	☐	Other_____	☐	☐
Kidney Diseases	☐	☐	Sexually Transmitted Disease	☐	☐	Do you smoke?	☐	☐
AIDS or HIV Infection	☐	☐	Stomach Troubles / Ulcers	☐	☐	Or use smokeless tobacco?	☐	☐
Thyroid Problem	☐	☐						

7. **Present dental needs**__________
8. Are you having any discomfort at this time?__________
9. Please describe__________
10. Are you aware of any swelling, sores, or lumps in your mouth?__________
11. Are you pleased with the appearance of your teeth?__________
12. If not, what would you like to change?__________

Over Please

	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 or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?....................	☐	☐
5. Have you had any head, neck or jaw injuries?......	☐	☐
6. 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?..............................	☐	☐

	Yes	No
7. Do you have frequent headaches?........................	☐	☐
8. Do you clench or grind your teeth?........................	☐	☐
9. Have you ever had braces?..	☐	☐
10. Have you ever had any prolonged bleeding following extractions?..	☐	☐

11. Other comments: ____________________

____

____

____

____

____

Responsible Party

Name of Person Responsible for this Account ____________________ Relationship to Patient ____________

Address ____________________ Home Phone ____________

Employer ____________________ Work Phone ____________

Is this Person Currently a Patient in our Office?

Authorization and Release

I certify that i have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis, photographs and the records of any treatment or examination rendered to me or my child to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance 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 on my behalf of my dependents.

X ____________________

Signature of patient or parent if minor