WELCOME

The benefits of a happy, healthy smile are immeasurable!
Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely.
The better we communicate, the better we can care for you.

PATIENT INFORMATION

Name (Mr., Mrs., Ms., Dr.) _____
Last First Middle

Residence/Address _____ City _____ Zip _____
Business/Address _____ City _____ Zip _____
Home Phone # _____ Business Phone # _____ Other (Cell, Pager, etc.) _____
Where do you prefer to be contacted? ___ Home ___ Business ___ Other (Please Specify)
E-mail Address _____
Date of Birth ___/___/___ Social Security # _____
If patient is a minor, name of mother and father or legal guardian _____
Place of Employment _____
Occupation/Former Occupation _____

SPOUSE INFORMATION

Name _____ Date of Birth ___/___/___
Employer _____ Occupation _____
Employer's Address _____ Employer's Phone # _____

IN CASE OF EMERGENCY

Person to Contact _____ Phone # _____
Friend/Relative Not Living with Patient _____ Phone # _____

REFERRAL SOURCE

Whom may we thank for referring you? _____
If not referred, how did you hear about us? _____

RESPONSIBLE PARTY (If Other Than Self)

Person Responsible for Payment of Account _____ Relationship _____
Mailing Address _____ City _____ State ___ Zip _____
Phone # _____ Date of Birth ___/___/___

INSURANCE INFORMATION

Name of Primary Dental Insurance Plan _____
Policy or Group # _____ Subscriber's Name (if different) _____ SSN of Subscriber _____
Name of Secondary Dental Insurance Plan _____
Policy or Group # _____ Subscriber's Name (if different) _____ SSN of Subscriber _____

There will be a charge for broken appointments without 24 hours notice. I understand that the responsibility for payment for dental services provided in this office for myself or my dependent is mine, regardless of insurance benefits. I also understand that payment is due and payable at the time services are rendered.

Signature _____ Date ___/___/_____

PATIENT MEDICAL HISTORY

Accurate answers will help us provide you the safest treatment experience. All information you provide is confidential.
If you need assistance or have a question, please ask.

Patient's Name _____ _____
Last First Middle Today's Date

Date of Birth ___/___/___ Date of last physical exam ___/___/___

Your PHYSICIAN'S name and phone # _____

Yes ___ No ___ Have you ever been hospitalized or had surgery?
If yes, please give year and reasons or types of operations. _____
_____
_____

Please mark YES or NO and CIRCLE any specific condition you currently have or have had previously.

MEDICATIONS

Have you ever taken any of the following:

Yes __ No __ Cortisone, steroids
Yes __ No __ Heparin, coumadin, blood thinners, anticoagulants
Yes __ No __ Antidepressants, sedatives, psychiatric medicine
Yes __ No __ Heart or blood pressure medications
Yes __ No __ Nitroglycerin
Yes __ No __ Fen-Phen, Pondimen, Redux

Please list all prescription and over-the-counter medications you are currently taking _____
_____
_____
_____

Yes __ No __ Any change in your general health in the last year?
Yes __ No __ Weight change greater than 10 pounds in the last year?
Yes __ No __ Do you exercise regularly?
Yes __ No __ Are you on a special diet?
Yes __ No __ Heart murmur, rheumatic fever
Yes __ No __ Mitral valve prolapse
Yes __ No __ Angina, chest pain
Yes __ No __ Heart attack, heart disease
Yes __ No __ Pacemaker, irregular heart beat
Yes __ No __ Heart surgery
Yes __ No __ High blood pressure
Yes __ No __ Stroke, embolus, thrombosis
Yes __ No __ Swollen ankles
Yes __ No __ Difficulty breathing at night
Yes __ No __ Asthma, hay fever
Yes __ No __ Tuberculosis, T.B.
Yes __ No __ Emphysema, pneumonia
Yes __ No __ Persistent cough, bronchitis
Yes __ No __ Seizure disorder, epilepsy, convulsion

Yes __ No __ Severe headaches, migraines
Yes __ No __ Fainting, dizziness
Yes __ No __ Eating disorder, anorexia, bulimia
Yes __ No __ Depression, psychosis, schizophrenia
Yes __ No __ Psychiatric care counseling
Yes __ No __ Neurological or neuromuscular disorder
Yes __ No __ Ulcer or stomach problem
Yes __ No __ Chronic diarrhea, intestinal problem
Yes __ No __ Kidney or bladder problem
Yes __ No __ Sexually transmitted disease
Yes __ No __ Hepatitis, cirrhosis, liver disease
Yes __ No __ Eye problems or disease
Yes __ No __ Sinus problems or infection
Yes __ No __ Ear problems or infection
Yes __ No __ Diabetes or high blood sugar
Yes __ No __ Swollen glands or lymph nodes
Yes __ No __ Been tested for HIV
Yes __ No __ HIV+, ARC, AIDS
Yes __ No __ Bleeding problem, hemophilia
Yes __ No __ Bruise easily, slow healing
Yes __ No __ Blood disorder, transfusion, sickle cell
Yes __ No __ Artificial joints
Yes __ No __ Arthritis, joint pain, back problems
Yes __ No __ Skin problem or disease
Yes __ No __ Cancer or tumor
Yes __ No __ Radiation treatment, chemotherapy
Yes __ No __ Past or present drug use including cocaine, crack, methamphetamine, etc.
Yes __ No __ Do you smoke? # of packs per day ___
For how long? _____
Yes __ No __ Chewing tobacco or snuff
Yes __ No __ Do you drink alcohol?
# of drinks per week _____
Yes __ No __ Do you participate in any sports? _____
_____

------ PLEASE CONTINUE ON OPPOSITE SIDE -----

PATIENT MEDICAL HISTORY CONTINUED

Please mark YES or NO and CIRCLE any specific condition you currently have or have had previously.

ALLERGIES

Do you have any of the following allergies:

Yes __ No __ Penicillin, sulfa, any antibiotic
Yes __ No __ Local anesthetics (novocaine, lidocaine, etc.)
Yes __ No __ Nitrous Oxide
Yes __ No __ Aspirin, codeine, or other pain medication
Yes __ No __ Hives, contact dermatitis, latex sensitivity
Yes __ No __ Allergic to another medication _____
_____

Yes __ No __ Do you have any disease, condition, or problem not listed above? _____
_____

WOMEN ONLY

Yes __ No __ Are you pregnant or possibly pregnant?
Yes __ No __ Are you nursing?
Yes __ No __ Are you taking birth control pills?

If any of the above YES answers require further explanation, please do so here

_____
_____

PATIENT DENTAL HISTORY

Accurate answers will help us provide you the safest treatment experience. All information you provide is confidential.
If you need assistance or have a question, please ask.

Patient's Name _____ _____
Last First Middle Today's Date

Date of Birth ___/___/___ Date of last dental exam ___/___/___

Please mark YES or NO and CIRCLE any specific condition you currently have or have had previously.

DENTAL HISTORY

Yes __ No __ Tooth or mouth pain recently
Yes __ No __ How nervous does dental treatment make you
___ Not at all ___ Slightly
___ Moderately ___ Extremely
Yes __ No __ Any unpleasant experience with dental treatment
If yes, please describe _____
_____
Yes __ No __ Are your teeth sensitive to heat, cold or anything else?
Yes __ No __ Do you clench or grind your teeth?
Yes __ No __ Jaw clicking, popping, or grinding
Yes __ No __ Jaw or TMJ pain
Yes __ No __ Ever worn partials or dentures
Yes __ No __ Orthodontic treatment/braces
Yes __ No __ Ulcers/sores in mouth or on lips
Yes __ No __ Unpleasant taste/bad breath
Yes __ No __ Swelling, lumps, bumps in mouth
Yes __ No __ Periodontal/gum surgery or disease
Yes __ No __ Oral surgery

Yes __ No __ Any complication with/reaction to past dental treatment?
Yes __ No __ Any injury to your teeth, mouth, jaws or head?
Reason for today's visit: _____
_____
How do you feel about the appearance of your front teeth?
_____
_____
Yes __ No __ Are you happy with the color of your teeth?
If no, please explain: _____
_____
Yes __ No __ Do you have any other dental concerns?
_____
_____
Previous dentists name _____
City _____
Last dental procedure and date _____
_____

If any of the above YES answers require further explanation, please do so here
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be very dangerous to my health. I also understand it is very important to report any changes in my medical or dental status to the dentist at the earliest time, and I agree to do so.

_____ _____ _____
Signature Date Relationship to patient if other than self

OFFICE USE ONLY

_____
_____
_____
_____
_____
_____
_____
_____

HEALTH HISTORY UPDATE

PATIENT'S NAME____

Last **First** **Date of Birth**

Have there been any changes in your health since your last dental visit? _____

Comments:

Patient: Include medications, medication changes, major illnesses, hospitalizations, operations, pregnancy, diet changes, allergies, high blood pressure, diabetes, or heart disease. .

__________________________ _____________________________________

Date **Patient Signature**

Have there been any changes in your health since your last dental visit? _____

Comments:

Patient: Include medications, medication changes, major illnesses, hospitalizations, operations, pregnancy, diet changes, allergies, high blood pressure, diabetes, or heart disease. .

__________________________ _____________________________________

Date **Patient Signature**

Have there been any changes in your health since your last dental visit? _____

Comments:

Patient: Include medications, medication changes, major illnesses, hospitalizations, operations, pregnancy, diet changes, allergies, high blood pressure, diabetes, or heart disease. .

__________________________ _____________________________________

Date **Patient Signature**