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

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City: _____ State / Zip _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Patient's Employer: _____ Spouse's Employer: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Spouse's Name: _____

RESPONSIBLE PARTY (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc. Sec: _____ Relationship: _____

DENTAL HISTORY

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

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

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

Check (✓) yes or 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? _____ 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

Although dental personnel 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 dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? O Yes O No If yes, please explain: _____

Physician's name? _____

Have you ever been hospitalized or had a major operation? O Yes O No If yes, please explain: _____

Have you ever had a serious head or neck injury? O Yes O No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? O Yes O No If yes, have you seen your physician: _____

Are you on a special diet? O Yes O No _____

Do you use tobacco? O Yes O No _____

Do you use controlled substances? O Yes O No _____

Pregnant? O Yes O No _____

Taking oral contraceptives? O Yes O No _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	O Yes O No	Diabetes	O Yes O No	Herpes	O Yes O No	Scarlet Fever	O Yes O No
Alzheimer's Disease	O Yes O No	Drug Addiction	O Yes O No	High Blood Pressure	O Yes O No	Shingles	O Yes O No
Anaphylaxis	O Yes O No	Easily Winded	O Yes O No	Hives or Rash	O Yes O No	Sickle Cell Disease	O Yes O No
Anemia	O Yes O No	Emphysema	O Yes O No	Hypoglycemia	O Yes O No	Sinus Trouble	O Yes O No
Angina	O Yes O No	Epilepsy or Seizures	O Yes O No	Irregular Heartbeat	O Yes O No	Spina Bifida	O Yes O No
Arthritis/Gout	O Yes O No	Excessive Bleeding	O Yes O No	Kidney Problems	O Yes O No	Stomach/Intestinal Disease	O Yes O No
Asthma	O Yes O No	Excessive Thirst	O Yes O No	Leukemia	O Yes O No	Stroke	O Yes O No
Blood Disease	O Yes O No	Fainting Spells/Dizziness	O Yes O No	Liver Disease	O Yes O No	Swelling of Limbs	O Yes O No
Blood Transfusion	O Yes O No	Frequent Cough	O Yes O No	Low Blood Pressure	O Yes O No	Thyroid Disease	O Yes O No
Breathing Problem	O Yes O No	Frequent Diarrhea	O Yes O No	Lung Disease	O Yes O No	Tonsillitis	O Yes O No
Bruise Easily	O Yes O No	Frequent Headaches	O Yes O No	Nursing	O Yes O No	Tuberculosis	O Yes O No
Cancer	O Yes O No	Genital Herpes	O Yes O No	Pain in Jaw Joints	O Yes O No	Tumors or Growths	O Yes O No
Chemotherapy	O Yes O No	Glaucoma	O Yes O No	Parathyroid Disease	O Yes O No	Ulcers	O Yes O No
Chest Pains	O Yes O No	Hay Fever	O Yes O No	Psychiatric Care	O Yes O No	Venereal Disease	O Yes O No
Cold Sores/Fever Blisters	O Yes O No	Heart Pacemaker	O Yes O No	Radiation Treatments	O Yes O No	Yellow Jaundice	O Yes O No
Congenital Heart Disorder	O Yes O No	Heart Trouble/Disease	O Yes O No	Recent Weight Loss	O Yes O No		
Convulsions	O Yes O No	Hemophilia	O Yes O No	Renal Dialysis	O Yes O No		
Cortisone Medicine	O Yes O No	Hepatitis A	O Yes O No	Rheumatic Fever	O Yes O No		
		Hepatitis B or C	O Yes O No	Rheumatism	O Yes O No		

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

Artificial Heart Valve	O Yes O No	Heart Attack/Failure	O Yes O No	Mitral Valve Prolapse	O Yes O No
Artificial Joint	O Yes O No	Heart Murmur	O Yes O No	Taking Blood Thinners	O Yes O No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

☐ Aspirin
☐ Barbiturates (Sleeping pills)
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other _____

AUTHORIZATIONS

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 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 the form to pay to 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 paid by insurance.

Signature _____ Date _____

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