Welcome!

Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you to maintain your dental health.

Patient Information

Patient Name: ______________________________ Date of Birth: ______________ Age: ________
Last Name, First Name Initial

Sex: ☐ M ☐ F Soc. Sec. # ______________________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Home Phone: ________________ Cell Phone: ________________ Work Phone: ________________

Address: ______________________ City: ________________ State: ______ Zip: __________

Email: ______________________________ Employer: ______________________________

Spouse's Name ______________________ Spouse's phone number: ______________________

Emergency Contact: ______________________ Relationship: ____________ Phone: ____________

Guarantor (if applicable): ______________________ Relationship to patient: ______________

How did you hear about us? : ☐ Patient referral ______________________ ☐ Doctor referral ______________
Patient's name Doctor's name

☐ Internet Search (Google, Bing, etc.) ☐ Insurance Company referral ☐ Office Sign ☐ Other: ______________

Insurance Information

Dental Insurance Company: ______________________ ID# ______________ Group # ____________

Subscriber's Name: ______________________ Date of Birth: ______________ Relation to patient: ____________

Subscriber's Address (if different from patient): ______________________________

Subscriber's Employer: ______________________ Insurance Company Phone # ______________________

Insurance Claims Address: ______________________________

Secondary Insurance Company: ______________________ ID# ______________ Group # ____________

Subscriber's Name: ______________________ Date of Birth: ______________ Relation to patient: ____________

Subscriber's Address (if different from patient): ______________________________

Subscriber's Employer: ______________________ Insurance Company Phone # ______________________

Insurance Claims Address: ______________________________

Dental History

Purpose of today's visit: ______________________ Currently experiencing dental discomfort? ______________

Previous Dentist: ______________________ Phone: ______________ Last Visit: ____________

Check all that apply: ☐ Clicking/popping in jaw ☐ Grinding/clenching teeth ☐ Sensitivity to hot/cold ☐ Sensitivity to Sweets
☐ Sensitivity when biting ☐ Bleeding gums ☐ Bad taste/bad breath ☐ Food catches between teeth ☐ Periodontal treatment

Are you happy with your smile ☐ yes ☐ no Are you interested in whitening? ☐ yes ☐ no Interested in Invisalign? ☐ yes ☐ no

Other issues you would like to discuss or address______________________________

Please complete both sides

Medical History

Physician's Name: ____ Phone # ___________________________

Date of last check up: ____________________ Hospitalizations and/or surgeries: ______________________________

WOMEN: Are you pregnant? ☐ yes ☐ no Nursing? ☐ yes ☐ no Taking prescription birth control? ☐ yes ☐ no

Have you ever taken a bisphosphonate medication such as Fosamax, Actonel, Atelvia, Didronel or Boniva? ☐ yes ☐ no

Has a physician or dentist ever recommended that you take antibiotics before a dental appointment? ☐ yes ☐ no

Check yes or no to whether you have ever had any of the following:

☐ Y ☐ N AIDS/HIV positive
☐ Y ☐ N Anaphylaxis
☐ Y ☐ N Anemia
☐ Y ☐ N Anticoagulant therapy Coumadin, Plavix, Xarelto, Eloquis, etc.
☐ Y ☐ N Arthritis/Rheumatism
☐ Y ☐ N Artificial Heart Valves
☐ Y ☐ N Artificial Joints Describe____________________
☐ Y ☐ N Asthma
☐ Y ☐ N Atopic (allergy prone)
☐ Y ☐ N Autoimmune disease Describe______________________
☐ Y ☐ N Back problems
☐ Y ☐ N Blood clotting disorder
☐ Y ☐ N Cancer Describe____________________
☐ Y ☐ N Chemical dependency
☐ Y ☐ N Chemotherapy
☐ Y ☐ N Circulatory problems

☐ Y ☐ N Cortisone treatments
☐ Y ☐ N Cough, persistent
☐ Y ☐ N Cough up blood
☐ Y ☐ N Diabetes
☐ Y ☐ N Dialysis
☐ Y ☐ N Eating disorder
☐ Y ☐ N Epilepsy
☐ Y ☐ N Fainting spells
☐ Y ☐ N Food allergies
☐ Y ☐ N GERD- Reflux disease
☐ Y ☐ N Glaucoma
☐ Y ☐ N Headaches
☐ Y ☐ N Heart attack
☐ Y ☐ N Heart murmur
☐ Y ☐ N Heart problems Describe____________________
☐ Y ☐ N Hemophilia/abnormal bleeding

☐ Y ☐ N Herpes
☐ Y ☐ N Hepatitis
☐ Y ☐ N High blood pressure
☐ Y ☐ N Jaw pain
☐ Y ☐ N Kidney disease Describe ________________
☐ Y ☐ N Liver disease Describe ________________
☐ Y ☐ N Material allergies-circle **Latex** wool metal chemicals
☐ Y ☐ N Mitral valve prolapse
☐ Y ☐ N Nervous problems
☐ Y ☐ N Osteoporosis
☐ Y ☐ N Pacemaker/Defibrillator
☐ Y ☐ N Psychiatric care
☐ Y ☐ N Rapid weight gain or loss
☐ Y ☐ N Radiation treatment
☐ Y ☐ N Respiratory disease
☐ Y ☐ N Rheumatic/Scarlet fever

☐ Y ☐ N Shingles
☐ Y ☐ N Shortness of breath
☐ Y ☐ N Sinus problems
☐ Y ☐ N Skin rash
☐ Y ☐ N Sleep disorder
☐ Y ☐ N Spina bifida
☐ Y ☐ N Stomache ulcer
☐ Y ☐ N Stroke
☐ Y ☐ N Surgical implant
☐ Y ☐ N Swelling of feet or ankles
☐ Y ☐ N Thyroid condition
☐ Y ☐ N Tobacco habit
☐ Y ☐ N Tonsillitis
☐ Y ☐ N Tuberculosis
☐ Y ☐ N Ulcerative colitis

Please list all current medications: ____

Please list all conditions not listed above: ____

ALLERGIES: ☐ Local anesthesia ☐ Aspirin ☐ Penicillin ☐ Sedatives ☐ Sulfa Drugs ☐ Codeine/Narcotics ☐ Other____________________

Authorization

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 this 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.

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

Signature of patient or guardian____ Date ________________________