



PLEASE COMPLETE ALL FORMS OF THE FOLLOWING CONFIDENTIAL INFORMATION

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC, AND THE ADA.

TODAY'S DATE: _____

NAME: _____ NAME I LIKE TO BE CALLED: _____

MAILING ADDRESS: _____ CITY: _____ ZIP: _____

STREET ADDRESS: _____ CITY: _____ ZIP: _____

BIRTHDAY: _____ MARITAL STATUS: _____ SS#: _____ EMAIL: _____

HOME #: (____) _____ WORK#: (____) _____ EXT: _____ CELL#: (____) _____

OCCUPATION: _____ EMPLOYER: _____

SPOUSE'S OR PARENT'S NAME: _____ BIRTHDAY: _____ SS#: _____

SPOUSE'S/PARENT'S OCCUPATION: _____ SPOUSE'S/PARENT'S EMPLOYER: _____

BEST CONTACT PHONE #: _____

PERSON RESPONSIBLE FOR ACCOUNT

CHECK IF SAME AS ABOVE; PROCEED TO NEXT SECTION

NAME: _____ SS#: _____

ADDRESS: _____ CITY: _____ ZIP: _____

RELATIONSHIP TO PATIENT: _____ BIRTHDATE: _____

EMPLOYER: _____ WORK #: (____) _____

DENTAL INSURANCE

EMPLOYEE NAME: _____ MEM ID#: _____ BIRTHDATE: _____

INSURANCE COMPANY: _____ INSURANCE: (____) _____

EMPLOYER: _____ GROUP#: _____

GETTING TO KNOW YOU

PLEASE LIST THE MEMBERS OF YOUR FAMILY THAT ARE PATIENTS IN OUR OFFICE: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? YELLOW PAGES WEBSITE FRIEND: _____

NEWSPAPER SIGN TV BILLBOARD MAILER MAGAZINE FACEBOOK GOOGLE

OTHER: _____

PERSON TO CONTACT IN CASE OF EMERGENCY (NOT LIVING WITH YOU):

NAME: _____ PHONE: (____) _____

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

HEALTH HISTORY - ANSWER ALL QUESTIONS

NAME: _____

Are you currently under the care of a physician?----- Y N

Physician's Name: _____ Phone: _____

Are you taking ANY prescriptions or over-the-counter medications? (IF YES, PLEASE LIST ALL MEDICATIONS) Y N

List: _____

Are you allergic to any medications or substances (including latex)?----- Y N

If yes, explain: _____

Is there any history of alcohol or chemical dependency that may affect the care we provide for you?----- Y N

If yes, explain: _____

Are you taking or have you ever taken Bisphosphonates for osteoporosis or any other medical conditions?----- Y N

If yes, circle all that apply: Fosamax Actonel Boniva Skelid Didronel Aredia Zometa

Have you ever been or are you currently being treated for a mental illness?----- Y N

If yes, explain: _____

HEART DISEASE----- Y N If yes, explain: _____

LUNG DISEASE----- Y N If yes, explain: _____

BLEEDING OR BLOOD DISORDER----- Y N If yes, explain: _____

DIABETES----- Y N If yes: Type I Type II Last HBA1C : _____

LIVER DISEASE----- Y N If yes, explain: _____

ARTIFICIAL JOINT/IMPLANT----- Y N If yes, explain: _____

SMOKE/VAPE/CHEW TOBACCO----- Y N If yes, how much per day _____

RECREATIONAL DRUGS----- Y N If yes, explain: _____

SEIZURES/EPILEPSY----- Y N

HIGH BLOOD PRESSURE----- Y N RADIATION OR CHEMOTHERAPY----- Y N

SINUS OR NASAL PROBLEM----- Y N HIV POSITIVE----- Y N

KIDNEY DISEASE----- Y N STOMACH ULCERS OR COLITIS----- Y N

GLAUCOMA----- Y N ARTHRITIS----- Y N

SLEEP APNEA----- Y N THYROID DISEASE----- Y N

Do you have any other disease, condition, or problem not listed that you think the doctor should know about?----- Y N

If yes, explain: _____

FOR WOMEN ONLY

Are you on any form of birth control?----- Y N Are you pregnant or nursing?----- Y N

DENTAL HISTORY

Are you having pain or discomfort at this time?----- Y N Explain: _____

Have you ever had a bad dental experience?----- Y N Explain: _____

Are you happy with the appearance of your smile?----- Y N Explain: _____

Is there anything else about going to the dentist that bothers you? _____

Please rate your level of dental anxiety: HIGH AVERAGE LOW NONE

I affirm that the above information is correct to the best of my knowledge. If I have any changes in my health history, or if my medicines change, I will inform my dentist at the next appointment without fail. I authorize the doctor/assistant to take x-rays, study models, photographs, or any other diagnostic aid deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform all recommended treatment, appropriate medications, and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose to employ assistance as deemed fit to provide recommended treatment.

Patient (or Guardian) Signature: _____ Date: _____