We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name _____ DOB _____ Date _____
Last First MI

Address _____ City/State_____ Zip _____

Soc. Sec. # _____ Home # _____ Cell # _____Wk # _____

Email _____ Relationship to Insurance Subscriber _____

Sex □ M □ F □ Single □ Married □ Widowed □ Separated □ Divorced

Employed By _____ Occupation _____

How did you hear about our office or who referred you? _____

In case of an emergency, notify _____ Phone _____

Responsible Party Information

The Responsible party is the person filling out this form and must be 18 or older. If the patient is a minor then the parent **who brought the minor patient in today is the responsible party; not the insured.** The responsible party cannot be a person who has not physically signed our forms. **If you are over 18 and you are the patient please just write "self" below**.

Name _____ DOB _____ Age _____
Last First MI

Address _____ City_____ Zip _____

Soc. Sec. # _____ Home # _____ Cell # _____Wk # _____

Email _____ Relationship to Ins. Subscriber _____

Sex □ M □ F □ Single □ Married □ Widowed □ Separated □ Divorced

Employed By _____ Occupation _____

Business Address_____ Business Phone _____

Dental Insurance Information

Subscriber Name _____ DOB _____
Last First MI

Soc. Sec. # _____ Subscriber ID # _____

Employer/Group Name _____ Group # _____

Dental Insurance Company Name _____ Phone _____

Secondary Dental Insurance Information

Subscriber Name _____ DOB _____
Last First MI

Soc. Sec. # _____ Subscriber ID # _____

Employer/Group Name _____ Group # _____

Dental Insurance Company Name _____ Phone _____

DENTAL HISTORY

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

Former Dentist _____ Address _____ Phone _____

Date of last dental visit _____ 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 Sensitivity to hot □ Y □ N Loose teeth or broken fillings □ Y □ N Clicking or popping jaw □ Y □ N Sores or growths in mouth

How often do you brush your teeth?_____ 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

Physician's Name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? □ Y □ N

If Yes, describe _____

Are you currently under physician care? □ Y □ N If yes, describe _____

Has a Doctor recommended that you **Pre-medicate** prior to dental care? □ Y □ N _____
Have you ever had a blood transfusion? □ Y □ N If yes, give approximate date _____

Have you ever taken Fen-Phen/Redux? □ Y □ N Are you on any Osteoporosis medication? (Fosamax) □ Y □ N
Women: Are you pregnant? □ Y □ N Nursing? □ Y □ N Taking birth control pills? □ Y □ N

Check (√) yes or no whether you have had any of the following:

□ Y □ N AIDS/HIV Positive
□ Y □ N Anaphylaxis
□ Y □ N Anemia
□ Y □ N Arthritis, Rheumatism
□ Y □ N Artificial heart valves
□ Y □ N Artificial joints
□ Y □ N Asthma
□ Y □ N Atopic (allergy prone)
□ Y □ N Back problems
□ Y □ N Blood disease
□ Y □ N Cancer
□ Y □ N Chemical dependency
□ Y □ N Chemotherapy
□ Y □ N Cortisone treatments
□ Y □ N Cough, persistent
□ Y □ N Coumadin
□ Y □ N Diabetes
□ Y □ N Epilepsy
□ Y □ N Fainting
□ Y □ N Food allergies
□ Y □ N Glaucoma
□ Y □ N Headaches
□ Y □ N Heart murmur
□ Y □ N Heart problems if yes describe: _____
□ Y □ N Hemophilia – bleeding
□ Y □ N Herpes
□ Y □ N Hepatitis
□ Y □ N High blood pressure
□ Y □ N Jaw Pain
□ Y □ N Kidney disease
□ Y □ N Liver Disease
□ Y □ N Material Allergies **(Latex)**
□ Y □ N Mitral valve prolapse
□ Y □ N Nervous problems
□ Y □ N Pacemaker/Heart Surgery
□ 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 Shortness of breath
□ Y □ N Sinus Problems
□ Y □ N Skin rash
□ Y □ N Spina Bifida
□ Y □ N Stroke
□ Y □ N Stomach Problems
□ Y □ N Surgical Implant
□ Y □ N Thyroid problems
□ Y □ N Tobacco habit
□ Y □ N Tonsillitis
□ Y □ N Tuberculosis
□ Y □ N Ulcer/Colitis
□ Y □ N Venereal disease

Is patient currently **taking any medications**? If yes list all:

_____

Does patient have drug allergies? Penicillin/Codeine If yes, list all:

_____

Dentist has reviewed medical history: _____ Date: _____

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand 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 dental insurance company 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 payments of benefits. **I understand that I am financially responsible for all charges whether or not paid by my insurance**. Payment is due in full at time of treatment.

Signature _____ Date _____