Welcome to our practice! We appreciate your honest answers to our questions.

Your answers are for our records only and will be considered confidential.

Patient Information

Name_____ Date_____

Address_____ Apt#_____

City_____ State_____ Zip_____

Telephone (Home)_____ (Work)_____ (Cell/Pager)_____

Date of Birth_____ Marital Status_____

Social Security Number_____

Occupation_____ Employer_____

Spouse or guardian_____

Address_____ Apt#_____

City_____ State_____ Zip_____

Telephone (Home)_____ (Work)_____ (Cell/Pager)_____

Other family members at this office ❑ yes ❑ no_____

Referred by_____

Financial Information

Primary Insurance Carrier

Employed By_____ Dental Ins. Co._____

Employee_____ Employee Date of Birth_____

Employee SSN_____ Union/Local #_____ Group #_____

Secondary Insurance Carrier

Employed By_____ Dental Ins. Co._____

Employee_____ Employee Date of Birth_____

Employee SSN_____ Union/Local #_____ Group #_____

Person Responsible for Paying This Account (if different than above)_____

Address_____ Apt#_____

City_____ State_____ Zip_____

Telephone (Home)_____ (Work)_____ (Cell/Pager)_____

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of the changes, it is not always possible. Therefore, it is your responsibility to know your individual coverage. Failing to do so will result in you, the patient, being responsible for all costs incurred. Please remember that your insurance policy is between you and your insurance company, not between the insurance company and your dentist. Payment is required at the time of service; however, if insurance is involved, payment will be expected on the copay. On major work, at least half payment is required at time of service. **If for any reason insurance does not pay in a reasonable time, payment will be expected from the patient**.

Most importantly, we are here to help in any way we can, and look forward to meeting your dental needs. Again, welcome to our practice.

I accept and understand the patient responsibilities outlined above:

Patient_____ **Date**_____

Medical History

Please circle any of the following that you have had or have presently.

Heart Attack	Heart Murmur	Allergies or Hives	Glaucoma
Heart Failure	Scarlet Fever	Hay Fever	Nervousness
Heart Disease	Rheumatic Fever	Asthma	Psychiatric Treatment
High Blood Pressure	Artificial Heart Valve	Emphysema	Epilepsy or Seizures
Angina Pectoris	Mitral Valve Prolapse	Cough	Fainting or Dizzy Spells
Heart Pacemaker	Congenital Heart Lesions	Tuberculosis (TB)	Drug Addiction
Blood Transfusion	Artificial Joints (Hip, Knee)	AIDS	Ulcers
Stroke	Rheumatism	HIV Positive	Fever Blisters
Anemia	Arthritis	Liver Disease	Cold Sores
Hemophilia	Kidney Disease	Hepatitis A	Bruise Easily
Diabetes	Thyroid Disease	Hepatitis B	Phen-Fen treatment
Sickle Cell Disease	Sinus Trouble	Hepatitis C	Cosmetic Surgery
Heart Surgery	Cortisone Medication	Yellow Jaundice	Venereal Disease (Syphilis, Gonorrhea)

Food Allergies If yes, what type?_____

Cancer If yes, what type?_____
Did you receive radiation / chemotherapy? (circle those that apply)

Are you allergic or have you reacted adversely to any of the following? (circle all that apply)

Penicillin/Amoxicillin	Aspirin	Nitrous Oxide (laughing gas)	Local Anesthetic
Erythromycin	Darvon	Valium	Novocaine/Xylocaine
Tetracycline	Codeine	Percodan	Scopolomine
Other Antibiotics	Demoral	Sleeping Pills	Latex

Other drugs or medications?_____

Are you now taking or using medication for: (Please circle)

Diabetes (Pills/Shots)	Blood (Liver/Iron Pills)	Blood thinners (Anticoagulants)
Nerves	Stomach Trouble (Ulcer/Other)	Seizures (Dilantin)
Sleeping Trouble	Headaches/Migraines	Thyroid
High Blood Pressure	Arthritis	Hormones (including birth control)
Heart Disease	Periodontal Disease	Allergies

Are you now taking, or have you taken in the past, bisphosphonates? ❑ yes ❑ no

These include: Fosamax, Didronel, Skelid, Bonefos, Aredia, Zometa, Actonel, Boniva

Please list medications you are currently taking (including over the counter, vitamins, minerals, and herbal supplements):

_____

_____

_____

Physician's name_____

Address_____Telephone_____

Date of last medical exam_____

Have you been a patient in a hospital during the past two years? ❑ yes ❑ no

If yes, what for?_____

Have you ever used tobacco products? ❑ yes ❑ no

If yes, do you currently use them?___How frequently?_____

Following injuries, have you ever had bleeding problems? ❑ yes ❑ no

Do injuries/cuts take longer to heal now than previously? ❑ yes ❑ no

Have you had eye trouble recently? ❑ yes ❑ no

Have you recently lost weight unintentionally? ❑ yes ❑ no

Is there a history of diabetes in your family? ❑ yes ❑ no

Do you urinate more than 6 times a day? ❑ yes ❑ no

Are you currently pregnant? ❑ yes ❑ no

Are you currently on a prescribed diet? ❑ yes ❑ no

If yes, for what reason?_____

Have you been treated for alcoholism or chemical dependency? ❑ yes ❑ no

Have you ever needed premedication prior to dental appointments? ❑ yes ❑ no

Dental History

Date of last dental visit_____
Date of last dental cleaning_____
Dentist's Name_____
Address_____
Telephone_____

Are you having pain or discomfort at this time? ❑ yes ❑ no
Have you come to this office for relief of pain? ❑ yes ❑ no
If yes, have you been in pain for more than 3 weeks? ❑ yes ❑ no
If yes, where is the pain?_____
Do you have unreplaced missing teeth? ❑ yes ❑ no
If yes, why have you not replaced them?_____
Do you have difficulty swallowing? ❑ yes ❑ no
Do your gums bleed when brushing your teeth? ❑ yes ❑ no
Have you ever been told you have periodontal disease? ❑ yes ❑ no
Is any part of your mouth sensitive to temperature or pressure? ❑ yes ❑ no
If yes, which part?_____
Does food catch between your teeth? ❑ yes ❑ no
If yes, where?_____
Have you had any serious trouble associated with any previous dental treatment? ❑ yes ❑ no
If yes, briefly describe_____
Do you have any pain or soreness around the eyes or ears? ❑ yes ❑ no
Do you have any unpleasant taste or odor in your mouth? ❑ yes ❑ no
Do you ever get cold sores or canker sores? ❑ yes ❑ no
Do you ever feel that you have a dry mouth? ❑ yes ❑ no
Are you dissatisfied with your teeth or their appearance? ❑ yes ❑ no
Does it seem you always have something to be treated when you visit a dentist? ❑ yes ❑ no
In the past, have you required a lot of dental work? ❑ yes ❑ no
Have you ever had a bad experience in the dental office? ❑ yes ❑ no
How do you feel about going to the dentist (circle the best answer):
No Problem Apprehensive Scared

Occlusal Screening

Do you wear complete and/or partial dentures? ❑ yes ❑ no
If yes, upper, lower, or both?_____
If yes, how long have you worn dentures?_____
Do any members of your family, including your parents, wear dentures? ❑ yes ❑ no
Have you had prior orthodontic treatment (braces)? ❑ yes ❑ no
Are you aware of any problems with snoring? ❑ yes ❑ no
Have you ever been diagnosed with sleep apnea? ❑ yes ❑ no
Have you ever been diagnosed with TMJ/TMD? ❑ yes ❑ no
Do you wear a bite splint/night guard? ❑ yes ❑ no
If yes, how frequently?_____
Do you clench or grind your teeth during the day? ❑ yes ❑ no
Have you been made aware of clenching or grinding during the night? ❑ yes ❑ no
Do you have chronic headaches or neck and shoulder pains? ❑ yes ❑ no
Do you ever wake up with an awareness of, or about, your teeth or jaw as if you have had them clenched in your sleep? ❑ yes ❑ no
Do you have any awareness in the muscles of your neck or shoulders? ❑ yes ❑ no
Do you have a tight or stiff neck? ❑ yes ❑ no
Do you now, or have you ever had, pain in your jaw joint or the sides of your face (in and about the ears)? ❑ yes ❑ no
Do you ever have a clicking jaw joint? ❑ yes ❑ no
Have you ever experienced an inability to move your jaw or open widely? ❑ yes ❑ no
Which side of your mouth do you chew on? Right Left Both

I have completed this preclinical examination questionnaire to the best of my knowledge

Patient_____ Date_____

Witness_____ Date_____

Doctor_____ Date_____

Medical history updates

Patient_____ Witness_____ Date_____

Patient_____ Witness_____ Date_____

Patient_____ Witness_____ Date_____

Patient_____ Witness_____ Date_____

Authorization to pay benefits to dentist:

I hereby authorize payment directly to the below named dentist of the benefit otherwise payable to me for his services as described, but not to exceed the reasonable and customary charges for those services.

Employee's Signature_____ Date_____

Authorization to release information:

I authorize the below named dentist to release any information relating to my treatment for insurance purposes, including radiographs (x-rays) and study models.

Patient's Signature_____ Date_____

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