



**PATIENT INFORMATION** **CONFIDENTIAL**

*Welcome!*

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Patient#: \_\_\_\_\_  
first middle last

Address: \_\_\_\_\_ email: \_\_\_\_\_  
street city state zip

**TELEPHONE**

Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

Home: \_\_\_\_\_ Fax: \_\_\_\_\_

When is the best time to reach you? \_\_\_\_\_

Best day: \_\_\_\_\_ Where: \_\_\_\_\_

In the event of an emergency, who should we contact?

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Work#: \_\_\_\_\_ Home#: \_\_\_\_\_

**Birthdate:**

\_\_\_\_\_

**✓ Check appropriate box:**

- |                                  |                                    |
|----------------------------------|------------------------------------|
| <input type="checkbox"/> Minor   | <input type="checkbox"/> Single    |
| <input type="checkbox"/> Married | <input type="checkbox"/> Divorced  |
| <input type="checkbox"/> Widowed | <input type="checkbox"/> Separated |

Patient's or Parent's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_  
street city state zip

Spouse or parent's name: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Driver License Number: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

**RESPONSIBLE PARTY**

If patient is a minor, please fill out below.

Name of person responsible for this account: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
street city state zip

Home Phone: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Driver's license #: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Is this person currently a patient in our office?  Yes  No

# MEDICAL HEALTH HISTORY

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of last health care exam: \_\_\_\_\_ What was this exam for? \_\_\_\_\_

Have you been hospitalized in the last 5 years? (Please circle)      No      Yes

If yes, reason: \_\_\_\_\_

Are you currently receiving care?      No      Yes      If yes, nature of care: \_\_\_\_\_

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. \_\_\_\_\_
2. \_\_\_\_\_

Please mark yes or no if you have or have had any of the following:

|  |    |     |   |    |     |
|--|----|-----|---|----|-----|
| Heart Murmur (mitral valve prolapse)     | No | Yes | Latex Sensitivity   | No | Yes |
| Anemia                                   | No | Yes | H.I.V. Infection/AIDS                                     | No | Yes |
| Diabetes                                 | No | Yes | Cancer, Osteoporosis, Multiple Myeloma                    | No | Yes |
| Epilepsy                                 | No | Yes | Do you consume any form of grapefruit?                    | No | Yes |
| Hepatitis, Any Form                      | No | Yes | Are you taking Tagamet (Cimetidine)?                      | No | Yes |
| Rheumatic Fever                          | No | Yes | Do you take antacids?                                     | No | Yes |
| Asthma                                   | No | Yes | Are you allergic to or have you had a reaction to:        |    |     |
| HIV Positive or AIDS Related Complex     | No | Yes | Local Anesthetics?  | No | Yes |
| Emphysema or other Respiratory Illnesses | No | Yes | Penicillin?   | No | Yes |
| Abnormal Heart Condition                 | No | Yes | Aspirin?  | No | Yes |
| Kidney Disease                           | No | Yes | Codeine, Valium or other sedatives?                       | No | Yes |
| Heart (Surgery, Disease, Attack)         | No | Yes | Are you a smoker? If yes, How much per day?               | No | Yes |
| Psychosis                                | No | Yes | Abnormal Blood Pressure? Please indicate.      /S      /D | No | Yes |
| Sore/Enlarged Lymph Nodes                | No | Yes | Are you required to premedicate before dental treatment?  | No | Yes |
| Previous Biopsies                        | No | Yes | Do you/have you ever take Fosamax, Actonel or Boniva?     | No | Yes |
| Slow Healing Mouth Sores                 | No | Yes | If yes, please indicate how long:                         |    |     |
| Other Infections                         | No | Yes | Are you taking any herbal supplements?                    | No | Yes |
| Recurrent Illnesses                      | No | Yes | Other:  |    |     |
| Joint Replacement                        | No | Yes |   |    |     |
| Glaucoma                                 | No | Yes | Women: Are you pregnant?                                  | No | Yes |
| Abnormal Bleeding from a cut             | No | Yes | If no, are you planning a pregnancy in the near future?   | No | Yes |
| Liver Disease (including Jaundice)       | No | Yes | Are you a nursing mother?                                 | No | Yes |
| Unintentional Weight Loss/Gain           | No | Yes | Are you taking birth control pills?                       | No | Yes |

Please list any medications you are currently taking:

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Weight: \_\_\_\_\_

Diet: Restricted Diet \_\_\_\_\_

How many meals a day \_\_\_\_\_

Food Allergies \_\_\_\_\_

Sugar in your diet     None     Slight     Moderate     High

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.*

\_\_\_\_\_  
Patient (Print Name)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



PATIENT DENTAL HISTORY

Patient Name \_\_\_\_\_

- 1. Do your gums bleed while brushing or flossing? Yes No
2. Are your teeth sensitive to hot or cold liquid/foods? Yes No
3. Are your teeth sensitive to sweet or sour liquid/foods? Yes No
4. Do you feel pain to any of your teeth? Yes No
5. Do you have any sores or lumps in or near your mouth? Yes No
6. Have you had any head, neck or jaw injuries? Yes No
7. Have you experienced any of the following problems in your jaw?
a) Clicking? Yes No
b) Pain (joint, ear, side of face)? Yes No
c) Difficulty in opening or closing? Yes No
d) Difficulty in chewing? Yes No
8. Do you have frequent headaches? Yes No
9. Do you clench or grind your teeth? Yes No
10. Do you bite your lips or cheeks frequently? Yes No
11. Have you ever had any difficult extractions in the past? Yes No
12. Have you had any orthodontic work? Yes No
13. Have you ever had prolonged bleeding following extractions? Yes No
14. Have you ever had instruction on the correct method of brushing your teeth? Yes No
15. Have you ever had instructions on the care of your gums? Yes No
16. Have you ever had periodontal treatment or has it been recommended to you in the past? Yes No
17. Do you want your treatment done while sedated? Yes No

What is the reason for your visit today? \_\_\_\_\_

Date of last dental visit \_\_\_\_\_

What was done at your last dental visit? \_\_\_\_\_

Do you have any dental problems now? Yes No

If yes, please describe: \_\_\_\_\_

Are you satisfied with your teeth's appearance? Yes No

What would you change about your smile? \_\_\_\_\_

Do you brush, floss or use any other dental aids? \_\_\_\_\_

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe \_\_\_\_\_

Certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE X

PATIENT, PARENT, OR GUARDIAN

DATE



# INSURANCE INFORMATION

Please present your insurance card to the front desk.

Name of Insured: \_\_\_\_\_ Relationship: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Date employed: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Phone #: \_\_\_\_\_

**Do you have any secondary insurance?  Yes  No If yes, complete the following**

Name of Insured: \_\_\_\_\_ Relationship: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Employer: \_\_\_\_\_ Date employed: \_\_\_\_\_

Group #: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Insurance Phone #: \_\_\_\_\_

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**FINANCES**

Payment in full is expected at each appointment. For your convenience, we offer the following methods of payment. Please check the option which you prefer. If you have any questions concerning financial arrangements, it will be our pleasure to assist you. There will be a \$50 charge for appointments not cancelled within a 48 hour time period.

Cash                                       Personal Check  
 VISA                       MASTERCARD                       DISCOVER  
 American Express                       Care Credit

Card # \_\_\_\_\_

Exp. Date \_\_\_\_\_

**Authorization, Release, & Agreement to Pay for Services Rendered**

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payors and/or health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

I agree to pay for all professional fees and treatment. I further agree to pay any collection and legal fees on any balance over 45 days old, should this be a necessary means for collection.

\_\_\_\_\_  
*Signature of patient or parent if minor*

\_\_\_\_\_  
*Date*