Patient Information

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name:____ Date of birth:________________ Sex:_____ Age_______

Home address:____ City:_______________________ State:_____ Zip________

Phone [H]_____________________Cell ______________________ Work_________________ Email__________________________

Driver's license #:___________________________________ State______________ SS#____________________________________

Single { } Married { } Divorced { } Separated { } Partnered { } Widowed{ }

Emergency contact / Relationship: ____ Phone: _____________________

Employer/Occupation:___________________________________ Student/School:____

Whom may we thank for referring you? _____________________________________

Financial Information

Name of Person Responsible for this Account __________________________________ Relationship to Patient ____________________

Address ____ Phone # _______________________________

Primary dental insurance _____________________________ Employer ________________________________ SS#_______________

Subscriber name___________________________Relationship_________DOB___________ ID#_____________ Group #_________

Secondary dental insurance _____________________________ Employer ________________________________ SS#_____________

Subscriber name___________________________Relationship_________DOB___________ ID#_____________ Group #_________

I authorize and request my insurance company to pay directly to the dentist or 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 my dependents. If my account becomes assigned to a collection agency, I agree to pay the collection agency fee of 25%, court costs, and attorney fees. ***Signature of Responsible Party*** ____

Dental Health History

- ☐ Are you apprehensive about dental treatment?
- ☐ Have you had problems with previous dental treatment?
- ☐ Do you gag easily?
- ☐ Do you wear dentures?
- ☐ Does food catch between your teeth?
- ☐ Do you have difficulty in chewing your food?
- ☐ Do you avoid brushing any part of your mouth because of pain?
- ☐ Do your gums bleed easily?
- ☐ Do your gums bleed when you floss?
- ☐ Do you your gums feel swollen or tender?
- ☐ Have you ever noticed slow-healing sores in or around your mouth?
- ☐ Are your teeth sensitive?
- ☐ Do you feel twinges of pain when your teeth come in contact with:
  - ☐Hot foods or liquids?
  - ☐Cold foods or liquids?
  - ☐Sours?
  - ☐Sweets?
- ☐ Do you take fluoride supplements?
- ☐ Are you dissatisfied with your smile?
- ☐ Do you prefer to save your teeth?
- ☐ Do you want complete dental care?
- ☐ Do your jaws ever feel tired?
- ☐ Do you clench or grind your teeth frequently?
- ☐ Does your jaw get stuck so that you can't open freely?
- ☐ Does it hurt when you chew or open wide to take a bite?
- ☐ Do you have earaches or pain in front of your ears?
- ☐ Do you have any jaw symptoms or headaches upon awaking in the morning?
- ☐ Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?
- ☐ Do you need to squeeze your teeth together or shift your jaw so that your teeth bite evenly?
- ☐ Do you have more than one jaw position where your teeth fit together?
- ☐ Do you have temporomandibular disorder?
- ☐ Do you have pain in the face, cheeks, jaws, joints, throat or temples?
- ☐ Are you unable to open your mouth as far as you want?
- ☐ Do you wear a nightguard?
- ☐ History of orthodontic treatment? When?_________
- ☐ How often do you brush?_________________
- ☐ How often do you floss?_________________

Medical Health History

Primary Care Physician_______________________________

Heart Problems

- *Chest Pain*
- *Shortness of breath*
- *Blood pressure problem*
- *Heart murmur*
- *Heart valve problem*
- *Rheumatic fever*
- *Pacemaker*
- *Artificial heart valve*
- *Heart Disease*

Respiratory Problems

- *COPD*
- *Emphysema*
- *Asthma*
- *Tuberculosis*

Blood Problems

- *Easy bruising*
- *Frequent nosebleeds*
- *Abnormal Bleeding*
- *Anemia*
- *Ever had a blood transfusion?*

Allergy Problems

- *Hay fever*
- *Sinus problems*
- *Skin rashes*
- *Taking allergy medication*

Intestinal Problems

- *Ulcers/GERD*
- *Weight gain or loss*
- *Special diet*
- *Kidney or bladder problems*

Bone or Joint Problems

- *Arthritis*
- *Back or neck pain*
- *Joint replacement*
- *(total hip, knee, pins or implants)*
- ***Premedications required by physician***

- *Fainting Spells*
- *Stroke[s]*
- *Frequent or severe headaches*
- *Thyroid problems*
- *High cholesterol*
- *Persistent cough or swollen glands*
- *Cancer/Tumor____________________*

Are you allergic, or have you reacted adversely, to any of the following?

- *Local anesthetics [Novocaine"]*
- *Penicillin or other antibiotics _____________________*
- *Sulfa Drugs*
- *Barbiturates, sedatives or sleeping pills*
- *Aspirin, Acetaminophen or Ibuprofen*
- *Codeine, Demerol or other narcotics*
- *Reaction to metals*
- *Latex or rubber dam*
- *Iodine*

Physician Office Phone #______________________

- *Diabetes*
  - *Urinate more than 6 times a day*
  - *Thirsty or mouth is dry much of the time*
  - *Family history of diabetes*
- *Do you drink alcohol?*
  - *If so how much? _____________*
- *Do you smoke?*
  - *If so how much? _____________*
- *Hepatitis, jaundice or liver trouble*
- *Herpes or other STD*
- *HIV-positive/AIDS*
- *Glaucoma*
- *Do you wear contact lenses?*
- *History of head injury?*
- *Epilepsy or other neurological disease?*
- *History of alcohol or drug abuse?*
- *If so, please describe: _________________*

During the past 12 months, have you taken any of the following?

- ***Antibiotics or sulfa drugs***
- ***Anticoagulants (e.g., Coumadin)***
- ***High blood pressure medicine***
- ***Tranquilizers***
- ***Insulin, Orinase, or similar drug***
- ***Aspirin***
- ***Digitalis or drugs for heart trouble***
- ***Nitroglycerin***
- ***Cortisone (steroids)***
- ***Natural remedies***
- ***Nonprescription drug/supplements***

Have you ever taken?

- ***Fosamax, Boniva, Actonel or any medications containing bisphosphonates?***

Women

- ***Are you taking contraceptives or other hormones?***
- ***Are you pregnant? Due Date___________***
- ***Are you nursing?***
- ***Have you reached menopause? If so, do you have any symptoms? _______ ___________________________________***

History of any hospitalization or surgeries________________ ____

Please list current medications and dosage:

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Patient/Parent Signature_________________________________ Date___________________ Dentist's Initials__________