WELCOME

The benefits of happy healthy smile are immeasurable!
Our goal is to help you reach and maintain maximum oral health.
Please fill out these forms completely.
The better we communicate, the better we can care for you.

1 ABOUT YOU

Today's Date: _____

Name: _____
LAST FIRST MI MR MISS MRS MS DR

I wish to be called: _____ ☐Male ☐Female

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Child

Birth date: _____ Age: _____ SS#: _____

Home Address: _____
APT#

_____
CITY STATE ZIP

Mailing Address: _____
(IF DIFFERENT) APT#

_____
CITY STATE ZIP

Home #: _____ Mobile/Other #: _____

Work #: _____ Driver's License: _____

Where do you prefer to receive calls? ☐ Home ☐ Work ☐ Email ☐ Text

Email: _____

Employer: _____

Occupation: _____

School / College: _____

Who referred you? _____

Other family members seen by us: _____

_____

Previous / Present Dentist: _____
(Please Circle)

Last Dental Visit: _____

Hobbies: _____

Continue on Back of Form

2 SPOUSE INFORMATION

Their Name: _____

Employer: _____ Work #: _____

SS #: _____ Birth date: _____

3 DENTAL INSURANCE

Insured's Name: _____

Relation to Patient: _____

Insured's DOB: _____ SS #: _____

Insured's Employer: _____

Date Employed: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

ID# / Policy #: _____

Do you have Secondary Dental Insurance? ☐ No ☐ Yes

4 Person Responsible for Account

Name: _____ DL #: _____

Relationship: _____ SS #: _____

Work #: _____ Home #: _____ Mobile #: _____

Billing Address: _____ APT#

_____

CITY STATE ZIP

Employer: _____

5 Emergency Contact

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

Name: _____ Relation: _____

Wk #: _____ Hm #: _____ Cell #: _____

6 Payments

For your convenience, we offer the following methods of payment.

☐ Cash ☐ Check ☐ Visa ☐ MC ☐ Amex ☐ Care Credit ☐ Discover

☐ I wish to discuss financial arrangements.

Payment is due in full at the time of treatment.

MEDICAL HISTORY

Physician's Name: _____

Phone #: _____ Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician?: ☐ No ☐ Yes

Please explain: _____

Are you talking blood thinner medication? ☐ No ☐ Yes

Are you taking any prescription/over-the-counter drugs? ☐ No ☐ Yes (Please list)

_____

_____

For Women Are you taking birth control pill? ☐ No ☐ Yes

Are you pregnant? ☐ No ☐ Yes Weeks: _____

Are you nursing? ☐ No ☐ Yes

Are you **allergic** to any of the following drugs?

Y N	Aspirin	Y N	Sulfa	Y N	Erythromycin	Y N	Dental Anesthetics
Y N	Codeine	Y N	Tetracycline	Y N	Penicillin	Y N	Latex

Please list other drugs that you are allergic to: _____

_____

Preferred Pharmacy: _____

Do you have or have you had any of the following?

Y N Anemia
Y N Angina/Chest Pains
Y N Arthritis
Y N Artificial Devices
Y N Asthma/Respiratory Problems
Y N Cancer
Y N Cardiac Pacemaker
Y N Diabetes
Y N Emphysema/Tuberculosis
Y N Epilepsy/Convulsions
Y N Glaucoma
Y N Heart Attack/Heart Disease
Y N Heart Murmur
Y N Heart Stents
Y N Hepatitis/Jaundice
Y N High/Low Blood Pressure
Y N HIV or AIDS
Y N Joint Replacement or Implant
Y N Kidney Disease
Y N Leukemia
Y N Liver Disease
Y N Mental Illness
Y N MVP
Y N Osteoporosis
Y N Radiation/Chemo
Y N Rheumatic Fever
Y N Seizures/Fainting
Y N Sexually Transmitted Diseases
Y N Stomach Troubles/Ulcers
Y N Stroke
Y N Thyroid Problems
Y N Tobacco Use
Y N Tuberculosis

Please list other serious medical condition(s) you may have:

_____

Continue on Back of Form

8 DENTAL HISTORY

Why have you come to the dentist today? _____

_____

Are you currently in pain? ☐ No ☐ Yes

Are your teeth sensitive to hot/cold foods/liquids? ☐ No ☐ Yes

Do you have sores or lumps in or near your moth? ☐ No ☐ Yes

Do you now or have you ever experienced pain/discomfort in your jaw joint, (TMJ/TMD)? ☐ No ☐ Yes

Do you clench or grind your teeth? ☐ No ☐ Yes

Have you ever had difficult extractions in the past? ☐ No ☐ Yes

Have you ever had Botox® or Dermal Fillers? ☐ No ☐ Yes

Your current dental health is? ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ No ☐ Yes

Do your gums ever bleed? ☐ No ☐ Yes

Would you like whiter teeth? ☐ No ☐ Yes

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of toothbrush? ☐ Hard ☐ Medium ☐ Soft

Have you ever had instructions on the care of your gums? ☐ No ☐ Yes

9 AUTHORIZATION AND RELEASE

I authorize the dentist to release any information, diagnosis and records of treatment/examination rendered to me or my child to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist 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 to me or my dependents.

_____

Signature of Patient or Parent Date

10 INFORMED CONSENT

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

_____

Signature of Patient or Parent Date