WELCOME

ACCT#:

TODAYS DATE:

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

PATIENT INFORMATION

Name:	Age:	Birth Date:	☐ Male ☐ Female
Nickname / Preferred Name:	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated		
Physical Address:			
Mailing Address:			
Primary Phone #: ☐ Cell	Alternate Phone #: ☐ Cell		
Work Phone #:	E-mail Address:		
Best Time to Call: ☐ 7 am - 9 am ☐ 9 am - 12 pm ☐ 12 pm - 5 pm ☐ 5 pm - 8 pm ☐ Anytime			
Driver's License #:	Social Security #:		
Employer:	Occupation:		
Employer Address:			
How were you referred to our office?			
General Physician:			
Medical Group:	Phone #:	Fax #:	
General Dentist:			☐ Current ☐ Prior
Dental Group:	Phone #:	Fax #:	
Orthodontist/Other Specialist:			☐ Current ☐ Prior
Dental Group:	Phone #:	Fax #:	
List other immediate family not currently seen by us yet:	1)	Age:	
2)	Age:	3)	Age:

RESPONSIBLE PARTY

Please complete this section, if the patient is a minor and/or a dependent.

Name:	Relation to Patient:
Billing Address:	
Employer:	
Employer Address:	
Primary Phone #: ☐ Cell	
Alternate Phone #: ☐ Cell	
E-mail Address:	Birth Date:
Social Security #:	Drivers License #:

EMERGENCY CONTACT

Please provide information of a friend or relative living in the area, but not with you.

Name:
Relation to Patient:
Address:
City/State/Zip:
E-mail Address:
Primary Phone #: ☐ Cell
Alternate Phone #: ☐ Cell

PRIMARY DENTAL INSURANCE

Insured's Name:	
Relation to Patient:	
Social Security #:	Birth Date:
Insured's Employer:	
Employer Address:	
Insurance Provider:	
Group/Insurance #:	

SECONDARY DENTAL INSURANCE

Insured's Name:	
Relation to Patient:	
Social Security #:	Birth Date:
Insured's Employer:	
Employer Address:	
Insurance Provider:	
Group/Insurance #:	

SIGNATURE REQUIRED

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees, and may, at the discretion of the office, use the service of one or more credit reporting services. I hereby authorize payment directly to the dentist. Payment is due in full at the time of treatment unless prior arrangements have been approved. I understand that this practice provides space, equipment, support personnel, and administrative services to facilitate each dentist to focus on patient care. The individual dentists practicing at this practice are not agents or employees of this practice. Each of them exercise independent professional judgement in the nature and manner of dental care and treatment provided. I acknowledge that I am aware that all of the dentists are not employee agents of this dental group. My signature acknowledges receipt of the Dental Materials Fact Sheet (DMFS) and the notice of the Privacy Practices (HIPAA).

Signature:	Date:

Our office is committed to meeting or exceeding the standard of infection control mandated by OSHA, the CDC, and the ADA.

Please complete other side of form.

ACCT#: __________

DENTAL HISTORY

What is the reason for your dental visit today?

How would you rate your current dental health? ☐ Good ☐ Fair ☐ Poor | Date of Last Dental Visit:

How frequently do you floss? | How frequently do you brush? | Type of bristles: ☐ Soft ☐ Medium ☐ Hard

Yes No

HAVE you or have you EVER HAD the following?

- ☐ ☐ Been advised to participate in an oral hygiene program.
- ☐ ☐ Been aware of grinding your teeth.
- ☐ ☐ Been consulted or received treatment by an orthodontist.
- ☐ ☐ Been informed of missing or extra teeth.
- ☐ ☐ Been interested in avoiding the need for dentures.
- ☐ ☐ Been treated for periodontal disease.
- ☐ ☐ Been under unusual stress.
- ☐ ☐ Bled from the teeth or gums.
- ☐ ☐ Disliked your smile.
- ☐ ☐ Endured injuries to the face or mouth.
- ☐ ☐ Experienced pain in the ears. ☐ Left ☐ Right
- ☐ ☐ Family member(s) received/interested in orthodontic treatment.
- ☐ ☐ Sucked your thumb or finger. Until what age? __________
- ☐ ☐ Suffered an unfavorable dental experience.
- ☐ ☐ Suffered from dental pain.
- ☐ ☐ Suffered from TMJ or pain in the Jaw Joints.

Other: __________

MEDICAL HISTORY

How would you rate your current physical health? ☐ Good ☐ Fair ☐ Poor | Age: | Height: | Weight:

Yes No

HAVE you or have you EVER HAD the following?

- ☐ ☐ **Abnormal Bleeding** associated with previous extractions, surgery or trauma.
  - ☐ ☐ Bruise easily.
  - ☐ ☐ High or low blood pressure.
  - ☐ ☐ Persistent cough or coughed up blood.
  - ☐ ☐ Required a blood transfusion.
  - Please explain: __________
- ☐ ☐ AIDS or exposure to AIDS.
- ☐ ☐ Asthma or hay fever.
- ☐ ☐ Arthritis.
- ☐ ☐ Been prescribed or taken an Osteoporosis Drug. (Actonel, Boniva, Fosamax, Prolia, etc.)
- ☐ ☐ Blood disorders, such as anemia.
- ☐ ☐ Broken bone(s). Please explain: __________
- ☐ ☐ **Cardiovascular Disease** (heart trouble, heart attack, coronary occlusion, high blood pressure, arteriosclerosis or stroke.)
  - ☐ ☐ Congenital Heart Lesions.
  - ☐ ☐ Heart murmur.
  - ☐ ☐ Mitral valve prolapse.
  - ☐ ☐ Pain in chest upon exertion.
  - ☐ ☐ Rheumatic fever or rheumatic heart disease.
  - ☐ ☐ Required antibiotics or medication prior to dental treatment.
  - ☐ ☐ Shortness of breath after mild exercise.
  - ☐ ☐ Swelling of ankles.
- ☐ ☐ Currently under the care of a physician. Please explain: __________
- ☐ ☐ **Diabetes.**
  - ☐ ☐ Experience dry mouth.
  - ☐ ☐ Frequent thirst.
  - ☐ ☐ Frequent urination (6 times a day or more).
- ☐ ☐ Ever taken Fen-Phen.
- ☐ ☐ Experienced extremely high fever as a child.
- ☐ ☐ Experience fainting spells or seizures.
- ☐ ☐ Experienced serious medical problems in the last 5 years. Please explain: __________
- ☐ ☐ Frequently consume alcoholic beverages.
- ☐ ☐ Frequently consume caffeine beverages.
- ☐ ☐ Hepatitis, jaundice or liver disease.
- ☐ ☐ HIV positive.
- ☐ ☐ Hives or skin rash.
- ☐ ☐ Inflammatory Rheumatism (painful/swollen joints).
- ☐ ☐ Kidney trouble.
- ☐ ☐ Mental or physical disabilities. Please assist us in better accommodating such limitations. Please explain: __________
- ☐ ☐ Smoke or chew tobacco.
- ☐ ☐ Stomach ulcers.
- ☐ ☐ Surgery or x-ray treatment for a tumor, growth or other condition of the mouth or lips.
- ☐ ☐ **Surgical implant and/or prosthetic surgery.**
  - Please explain: __________
  - Date of surgery: __________
- ☐ ☐ Tendency to be frequently sick.
- ☐ ☐ Tonsils and adenoids removed.
- ☐ ☐ Tuberculosis.
- ☐ ☐ Venereal/Sexually Transmitted Disease.

Other: __________

Are you TAKING the following?

- ☐ ☐ Antibiotics or sulfa drugs.
- ☐ ☐ Anticoagulants (blood thinners).
- ☐ ☐ Aspirin.
- ☐ ☐ Cortisone (steroids).
- ☐ ☐ Digitalis or drugs for heart trouble.
- ☐ ☐ Insulin, Tolbutamide (Orinase) or similar.
- ☐ ☐ Medicine for high blood pressure.
- ☐ ☐ Nitroglycerin.
- ☐ ☐ Tranquillizers.

Other: __________

Are you ALLERGIC or have you ever REACTED ADVERSELY towards the following?

- ☐ ☐ Aspirin or other pain medication.
- ☐ ☐ Barbiturates, sedatives or sleeping pills.
- ☐ ☐ Iodine.
- ☐ ☐ Latex.
- ☐ ☐ Local Anaesthetics.
- ☐ ☐ Nickel or any other metals.
- ☐ ☐ Penicillin or other antibiotics.
- ☐ ☐ Sulfa drugs.

Other: __________

For females only. Please provide the correct response.

- ☐ ☐ Have you begun a menstruation cycle?
- ☐ ☐ Are you currently or possibly pregnant? If yes, how far along? __________
- ☐ ☐ Are you currently nursing?
- ☐ ☐ Are you currently on birth control?

SIGNATURE REQUIRED

I understand that any information that I have provided, including but not limited to my personal information, my medical and dental history, is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my personal information, medical status, or dental insurance.

Signature: | Date:

OFFICE USE ONLY

Comments/Notes/Updates:

I verbally reviewed the above medical/dental information with patient named herein. | Dr. Signature: | Date:

Date/Initial:	Date/Initial:	Date/Initial:	Date/Initial:	Date/Initial:	Date/Initial: