Thank you for selecting our dental healthcare team!

To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

The information you give is strictly confidential and will not be released to anyone without your written permission.

Patient # ____________ Social Security # ________________________ Date: ___________________

Patient Information

Name ______________________________ *Birth date* ____________ *Home Phone* ______________

Address ______________________________ *City* ______________ *State* ________ *Zip Code* ________

Check Appropriate Box: ☐ *Minor* ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Separated*

If Student, Name of School/College ____________________ *City* __________ *State* _____ ☐ *Full Time* ☐ *Part Time*

Patient's or Parent's Employer ________________________________ *Work Phone* ______________

Business Address ______________________ *City* ______________ *State* ________ *Zip Code* ________

Spouse or Parent's Name ____________________ *Employer* ________________ *Work Ph* ____________

Whom May We Thank for Referring You? ____

Person to Contact in Case of Emergency ______________________________ *Phone* ____________

Responsible Party

Name of Person Responsible for this Account ____________________________ *Relationship to Patient* __________

Address ____ *Home Phone* ______________

Driver's License # ______________ *Birth date* ____________ *Financial Institution* ______________

Employer ______________________________ *Work Phone* ______________ *SSN#* ______________

Is this Person Currently a Patient in our Office? ☐ *Yes* ☐ *No*

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ *Cash* ☐ *Personal Check* *Credit Card:* ☐ *Visa* ☐ *MasterCard* ☐ *Discover* ☐ *Healthcare Card*

Insurance Information

Name of Insured ____ *Relationship to Patient* __________

Birth date ________________________ *SSN#* ______________ *Date Employed* ______________

Name of Employer ______________________ *Union or Local #* ________ *Work Phone* ______________

Address of Employer ______________________ *City* ______________ *State* ________ *Zip Code* ________

Insurance Company ______________________ *Group #* ____________ *Policy/ID #* ______________

Ins. Co. Address ______________________ *City* ______________ *State* ________ *Zip Code* ________

How much is your deductible? __________ *How much have you used?* __________ *Max. Annual Benefit* __________

Describe any current problems. ____

____

____

Any of the following?: ☐ Pain ☐ Swelling ☐ Broken ☐ Appearance ☐ UR ☐ UL ☐ LR ☐ LL ☐ U/ANT ☐ L/ANT

Sensitive to: ☐ Hot ☐ Cold ☐ Pressure ☐ Sweets

Your Dental History

Last Dental Exam ______________________________

Last Cleaning ______________________________

Previous Dentist ______________________________

Address ______________________________

______________________ Phone ____________

How often did you see your previous dentist? ______________

How often do you brush your teeth? ______________

How long a period of time do you use a brush before replacing it?

____

Are you having any discomfort at this time? Yes No

Any difficulty in getting numb? Yes No

Any complications with extractions? Yes No

Are your teeth sensitive? Yes No

☐ cold ☐ hot ☐ sweet

Do you want your teeth straightened? Yes No

Are you a non-flosser? Yes No

Do you clean or pick you teeth other than with floss or a brush? Yes No

Do your gums bleed? Yes No
Do you eat between meals? Yes No
Does food wedge between your teeth? Yes No
Where? ______________________________
Do you grind or clench your teeth? Yes No
When: ______________________________
Have you ever been treated for TMJ? Yes No
Have you ever had gum treatment? Yes No
Do you feel you have bad breath at times? Yes No

Do you have an unpleasant taste in your mouth? Yes No
Are you aware of any swelling or lumps in your mouth? Yes No
Any pain in or around your ears? Yes No
Do you hear popping or clicking noises when opening or closing your mouth? Yes No
Do you breath easily through your nose? Yes No
Are you a mouth breather? Yes No
Do you gag easily? Yes No

Are you unhappy with the appearance of your teeth? Yes No
Do you want to upgrade the condition of your mouth? Yes No
Are you interested in cosmetic dentistry? Yes No
Do you want to replace missing teeth? Yes No

For Women Only:
Are you pregnant? Yes No
Are you nursing? Yes No
Are you taking oral contraception? Yes No

What do you fear most about dental visits? ______________________________
What changes would you make to your teeth? ______________________________
Are you taking any medications regularly? Yes No If yes, which ones? ______________________________
____

Family Doctor ______________________________ Last seen ______________
Specialist ______________________________ For what condition ______________________________
____
Birth date ______________________________ Age ________

Do you have, or have you ever had, any of the following? If yes, please mark with a check (✓).

____ Mitral Valve Prolapse
____ High Blood Pressure
____ Low Blood Pressure
____ Circulatory Problems
____ Nervous Problems
____ Radiation Treatments
____ Excessive Bleeding
____ Aids
____ Anemia
____ Asthma
____ Diabetes
____ Heart Attack
____ Latex Rubber Allergy
____ Kidney Disease
____ Cardiac Pacemaker

Allergies to:
____ Anesthetics
____
____ Drugs
____
____ Heavy Metals
____ Hepatitis
____ Herpes, Oral or Other
____ Malignancies
____ Measles
____ Mumps
____ Prosthesis
____ Emphysema
____ Liver Disease
____ Fainting Spells
____ Psychiatric Care
____ Rheumatic Fever

____ Scarlet Fever
____ Sinus Problems
____ Stroke
____ Typhoid Fever
____ Tonsillitis
____ Tuberculosis
____ Ulcer
____ Venereal Disease
____ Open Heart Surgery
____ HIV Positive
____ Joint Replacement Surgery
____ Thyroid Problems
____ Sexually Transmitted Disease
____ Glaucoma
____ Respiratory Problems
____ Heart Disease

Has your physician recommended pre-medication for any dental procedures? Yes No

Is there any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment: Yes No Please describe: ______________________________
____

Have there been any major surgeries or cancer treatments? Yes No Years they were performed: ______________________________
____

Other Family Members:
Name ______________________________ Age ________ Name ______________________________ Age ________
Name ______________________________ Age ________ Name ______________________________ Age ________
Name ______________________________ Age ________ Name ______________________________ Age ________
Name ______________________________ Age ________ Name ______________________________ Age ________

Signature ______________________________ Date ______________

Please sign and date here.