



All information provided is confidential

Patient Information		
Full Name _____	Today's Date _____	
Date of Birth _____	SSN# _____	Gender: <i>Male/Female</i> _____
Home Address _____	City _____	State _____ Zip _____
Phone (Home) _____	Work _____	Cell _____
Email Address _____		
Preferred contact method? _____	Home Phone _____	Cell Phone _____ Work Phone _____ Email _____
Patient or Parent 's Employer _____		Occupation _____
Business Address _____	City _____	State _____ Zip _____
Spouse or Parent's Name _____		Spouse's SSN _____
Spouse's Employer _____		

Referral Info:	
How did you hear about our practice?	
___ Internet: _____	Please Circle: <i>Google, Yahoo, Yelp, Angie's List, Website, Other</i> _____
___ Insurance Company _____	
___ Yellow pages _____	___ Friend/Family Member: if so, Name of Person _____ Other _____

Responsible Party	
Person Responsible for this Account _____	Relationship to Patient _____
Address _____	City _____ State _____ Zip _____
Home Phone _____	Work Phone _____ Drivers License # _____
Birthdate _____	SSN# _____
Employer _____	
Is this Person Currently a Patient in our Office? Yes ___ No ___	
For your convenience, we offer the following method of payment. Please circle the option you prefer. Payment in full is due at each appointment: <i>Cash Personal Check Visa Mastercard Amex</i>	

Insurance Information		
Name of Insured _____	Relationship to Patient _____	
Birthdate _____	SSN# _____	Date Employed _____
Name of Employer _____	Work Phone _____	
Employer Address _____	City _____	State _____ Zip _____
Insurance Company _____	Group # _____	Policy/ID# _____
Ins. Co. Address _____	City _____	State _____ Zip _____
How much is your deductible? _____	Max Annual Benefit? _____	
Do you have any additional insurance?	Yes No	If Yes, complete the following
Name of Insured _____	Relationship to Patient _____	
Birthdate _____	SSN# _____	Date Employed _____
Name of Employer _____	Work Phone _____	
Employer Address _____	City _____	State _____ Zip _____
Insurance Company _____	Group # _____	Policy/ID# _____
Ins. Co. Address _____	City _____	State _____ Zip _____
How much is your deductible? _____	Max Annual Benefit? _____	

Patient Medical History			
Physician _____	Office Phone _____	Date of Last Exam _____	
	<u>Yes</u> <u>No</u>		<u>Yes</u> <u>No</u>
1. Are you under medical treatment now?	<input type="checkbox"/> <input type="checkbox"/>	9. Are you allergic to or have you had any reactions to the following?	
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If Yes, please explain _____	<input type="checkbox"/> <input type="checkbox"/>	Local Anesthetics (e.g. Novocain)	<input type="checkbox"/> <input type="checkbox"/>
		Penicillin or other Anti-Biotics	<input type="checkbox"/> <input type="checkbox"/>
		Sulfa Drugs	<input type="checkbox"/> <input type="checkbox"/>
		Barbituates	<input type="checkbox"/> <input type="checkbox"/>
		Sedatives	<input type="checkbox"/> <input type="checkbox"/>
		Iodine	<input type="checkbox"/> <input type="checkbox"/>
		Aspirin	<input type="checkbox"/> <input type="checkbox"/>
		Any Metals (e.g. nickel, mercury)	<input type="checkbox"/> <input type="checkbox"/>
		Latex Rubber	<input type="checkbox"/> <input type="checkbox"/>
		Other _____	<input type="checkbox"/> <input type="checkbox"/>
3. Are you taking any medications including non-prescriptions? If yes, what? _____	<input type="checkbox"/> <input type="checkbox"/>	10. Women Only:	
		Are you pregnant or think you may be pregnant?	<input type="checkbox"/> <input type="checkbox"/>
4. Have you ever taken Phen-Fen/Redux?	<input type="checkbox"/> <input type="checkbox"/>	Are you nursing?	<input type="checkbox"/> <input type="checkbox"/>
5. Do you use tobacco?	<input type="checkbox"/> <input type="checkbox"/>	Are you taking oral contraceptives?	<input type="checkbox"/> <input type="checkbox"/>
6. Do you use controlled substances?	<input type="checkbox"/> <input type="checkbox"/>		
7. Are you wearing contact lenses?	<input type="checkbox"/> <input type="checkbox"/>		
8. Do you have or have you had any of the following?			
	<u>Yes</u> <u>No</u>		<u>Yes</u> <u>No</u>
High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/>	Heart Disease	<input type="checkbox"/> <input type="checkbox"/>
Heart Attack	<input type="checkbox"/> <input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/> <input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/>	Heart Murmur	<input type="checkbox"/> <input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/> <input type="checkbox"/>	Angina	<input type="checkbox"/> <input type="checkbox"/>
Fainting/Dizziness	<input type="checkbox"/> <input type="checkbox"/>	Frequently Tired	<input type="checkbox"/> <input type="checkbox"/>
Asthma	<input type="checkbox"/> <input type="checkbox"/>	Anemia	<input type="checkbox"/> <input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/> <input type="checkbox"/>	Emphysema	<input type="checkbox"/> <input type="checkbox"/>
Epilepsy/Convulsions/Seizure	<input type="checkbox"/> <input type="checkbox"/>	Cancer	<input type="checkbox"/> <input type="checkbox"/>
Leukemia	<input type="checkbox"/> <input type="checkbox"/>	Arthritis	<input type="checkbox"/> <input type="checkbox"/>
Diabetes	<input type="checkbox"/> <input type="checkbox"/>	Heart Trouble	<input type="checkbox"/> <input type="checkbox"/>
Kidney Disease	<input type="checkbox"/> <input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/> <input type="checkbox"/>
AIDS or HIV Infection	<input type="checkbox"/> <input type="checkbox"/>	Mitral Valve Problem	<input type="checkbox"/> <input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/> <input type="checkbox"/>	Stomach Troubles/Ulcer	<input type="checkbox"/> <input type="checkbox"/>
Bleeding Problems	<input type="checkbox"/> <input type="checkbox"/>	Herpes	<input type="checkbox"/> <input type="checkbox"/>
		Chest Pains	<input type="checkbox"/> <input type="checkbox"/>
		Easily Winded	<input type="checkbox"/> <input type="checkbox"/>
		Stroke	<input type="checkbox"/> <input type="checkbox"/>
		Hay Fever/Allergies	<input type="checkbox"/> <input type="checkbox"/>
		Tuberculosis/Lung Problems	<input type="checkbox"/> <input type="checkbox"/>
		Radiation Therapy/Chemo	<input type="checkbox"/> <input type="checkbox"/>
		Glaucoma	<input type="checkbox"/> <input type="checkbox"/>
		Recent Weight Loss	<input type="checkbox"/> <input type="checkbox"/>
		Liver Disease	<input type="checkbox"/> <input type="checkbox"/>
		Joint Replacement or Implant	<input type="checkbox"/> <input type="checkbox"/>
		Respiratory Problems	<input type="checkbox"/> <input type="checkbox"/>
		Sexually Transmitted Disease	<input type="checkbox"/> <input type="checkbox"/>
		Other _____	<input type="checkbox"/> <input type="checkbox"/>

Patient Dental History			
Name of Previous Dentist _____	Date of Last Exam _____		
Previous Dentist's Location _____	Date of Last Cleaning _____		
	<u>Yes</u> <u>No</u>		<u>Yes</u> <u>No</u>
1. Do your gums bleed while brushing or flossing?	<input type="checkbox"/> <input type="checkbox"/>	8. Do you have frequent headaches?	<input type="checkbox"/> <input type="checkbox"/>
2. Are you teeth sensitive to hot/cold	<input type="checkbox"/> <input type="checkbox"/>	9. Do you clench or grind you teeth?	<input type="checkbox"/> <input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour?	<input type="checkbox"/> <input type="checkbox"/>	10. Do you bite your lips or cheeks frequently?	<input type="checkbox"/> <input type="checkbox"/>
4. Do you feel pain to any of your teeth?	<input type="checkbox"/> <input type="checkbox"/>	11. Have you ever had any difficult extractions in the past?	<input type="checkbox"/> <input type="checkbox"/>
5. Do you have sores or lumps in/near mouth?	<input type="checkbox"/> <input type="checkbox"/>	12. Have you ever had any prolonged bleeding after extractions?	<input type="checkbox"/> <input type="checkbox"/>
6. Have you had any head, neck or jaw injuries?	<input type="checkbox"/> <input type="checkbox"/>	13. Have you had any orthodontic treatments?	<input type="checkbox"/> <input type="checkbox"/>
7. Have you ever experienced any of the following problems in your jaw?		14. Do you wear dentures or partials?	<input type="checkbox"/> <input type="checkbox"/>
Clicking	<input type="checkbox"/> <input type="checkbox"/>	If yes, date of placement _____	
Pain (joint, ear, side of face)	<input type="checkbox"/> <input type="checkbox"/>	15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	<input type="checkbox"/> <input type="checkbox"/>
Difficulty in opening/closing jaw	<input type="checkbox"/> <input type="checkbox"/>	16. Do you like your smile?	<input type="checkbox"/> <input type="checkbox"/>
Difficulty in chewing	<input type="checkbox"/> <input type="checkbox"/>		

Authorization and Release

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

X _____
Signature of patient (or parent if minor) Date