WELCOME

Thank you for selecting our dental healthcare team! To help us meet all your dental healthcare needs, please fill out this form completely.

Patient Information (Confidential) Today's Date _____

Name _____ Birthdate _____ Age _____ Gender: ☐M ☐F

(Last Name) *(First Name)*

Address _____ City _____ Zip _____ SSN # _____

Email _____ Home Ph _____ Cell Ph _____

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

If Student, Name of School / College _____ Grade level _____

Patient's / Guardian's Employer _____ Work Ph: _____

Spouse of Patient/Guardian's Name _____

Person to Contact in case of emergency _____ Ph. _____

Whom may we thank for referring you? _____

I will be paying for today's service by:

☐ *Cash* ☐ *Check* ☐ *Credit Card* ☐ *Medicaid* ☐ *I would like to discuss payment options*

Responsible Party

Name of the Person Responsible for this Account _____ Relationship to Patient _____

Address (if different from above) _____

Email _____ Home Ph. _____ Cell Ph. _____

Driver's License # _____ Birthdate _____

Employer _____ Work Ph. _____ SSN # _____

Is this person currently Patient in our office? ☐ Yes ☐ No

Dental Insurance Information

Name of the Insured _____ Relationship to Patient _____

Birthdate _____ SSN# _____ Date Employed _____

Name of the Employer _____ Work Ph. _____

Address of Employer _____

Insurance Company _____ Insurance Company Ph. _____

Group # _____ Policy # _____ Medicaid # _____

Additional Dental Insurance ☐ Yes ☐ No If yes, please complete the following:

Name of the Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Date Employed _____

Name of the Employer _____ Work Ph. _____

Address of Employer _____

Insurance Company _____ Insurance Company Ph. _____

Group # _____ Policy # _____ Medicaid # _____

Acknowledgement of Receipt of Notice of Privacy Practices

~ You may refuse to sign this acknowledgement ~

I, _____ , have read a copy of this office's Notice of Privacy Practices and this acknowledgement will be kept of record for the following mentioned patient.

_____ _____

(signature of patient or guardian) *(Date)*

Patient Name: _____

Patient Medical History

Physician Name _____

Office Ph. _____ Date of Last Exam _____

	YES	NO
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 yrs.? _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, please explain. _____	☐	☐
4. Have you ever taken Fen-Phen / Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐

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

	YES	NO		YES	NO		YES	NO
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Value Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Psychiatric Problems	☐	☐

Other

	YES	NO
(if yes, please describe) _____		
8. Do you have any allergies or allergic reactions? _____	☐	☐
9. Do you have persistent cough not associated with a known illness?	☐	☐

10. Women only:

	YES	NO
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing	☐	☐
Are you taking oral contraceptives?	☐	☐

	YES	NO
11. Do you need to be **premedicated** before dental procedures due to medical conditions (i.e. heart murmurs)? If yes, please describe: _____	☐	☐

Patient Dental History

General Dentist Name _____

Office Ph. _____ Date of Last Exam _____

	YES	NO		YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☐	8. Do you have frequent headaches?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐	9. Do you clench or grind your teeth?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐	10. Do you bite your lips or cheeks?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐	11. Have you had any difficult extractions before?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐	12. Have you had any prolonged bleeding following following extractions?	☐	☐
6. Have you had any head, neck, or jaw injuries?	☐	☐	13. Have you had any orthodontic treatment?	☐	☐
7. Have you ever experienced any of the following in your jaw.					
Clicking	☐	☐			
Pain (joint, ear, side of face)	☐	☐			
Difficulty in opening or closing	☐	☐			
Difficulty in chewing	☐	☐			

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 payers and/or health practitioners. I authorized and request my insurance 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 services rendered on my behalf or my dependents.***

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

Date	Age	Note / Recommendation	Next Visit

Doctor's Signature _____ Date _____