Welcome!

We would like to welcome you to our office. Our goal is to make everyone's visit pleasant and educational. We strive to teach exceptional oral care that will enable you to have a beautiful smile that lasts a lifetime.

1 Patient Information

Today's Date _____

First Name _____ MI _____

Last Name _____

Birthdate _____ Age _____ SS# _____

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Address _____

_____

Home # _____ Cell # _____

Employer _____ Work # _____

Occupation _____

Email _____

Referred by _____

Emergency Contact Name: _____

Emergency Contract Phone # _____

2 Responsible Party

First Name _____ MI _____

Last Name _____

Birthdate _____ Age _____ SS# _____

Employer _____ Work # _____

Occupation _____

Employer's Address _____

_____

3 Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone _____

Plan _____ Group _____ Policy _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate _____ SS# _____

Policy Owner's Employer _____

Employee's Address _____

_____

Orthodontic Coverage? ☐ Yes ☐ No

4 Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone _____

Plan _____ Group _____ Policy _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate _____ SS# _____

Policy Owner's Employee _____

Employee's Address _____

_____

Orthodontic Coverage? ☐ Yes ☐ No

5 Dental History

Purpose of today's visit _____

Previous Dentist _____

Date of last visit _____

What was done _____

Last Cleaning _____

How often do you brush _____ Gums bleed ☐ Yes ☐ No

Any ☐ Sensitive teeth ☐ Loose teeth ☐ Broken fillings

☐ Jaw pain ☐ Injuries to teeth

Explain _____

Unpleasant Dental Experience ☐ Yes ☐ No

Explain _____

Have you ever had ☐ Orthodontics ☐ Gum Treatment ☐ Implants

☐ Root Canal ☐ Oral Surgery ☐ Crowns ☐ Veneers

Are you happy with the appearance of your teeth?

☐ Yes ☐ No ☐ Color ☐ Position ☐ Smile

Have you ever had tooth whitening? ☐ Yes ☐ No

☐ In Office ☐ Overnight ☐ Drug Store

Are you interested in replacing any missing teeth? ☐ Yes ☐ No

Which method ☐ With Dentures ☐ Bridges ☐ Implants

Do you have any questions for the doctor? ☐ Yes ☐ No

I authorize the doctor to perform all recommended treatment agreed upon by me and to use the appropriate medication and therapy for such treatment in connection with _____ (NAME OF PATIENT). I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and give consent to the doctor to use and employ such assistant as deemed to provide recommended treatment.

6 Medical History

Physicians Name _____

Office Address _____

_____

Telephone _____

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

Explain _____

Has there been a recent change in your health? ☐ Yes ☐ No

Explain _____

Are you currently taking any prescription, over the counter or recreational drugs? ☐ Yes ☐ No

Explain _____

_____

_____

_____

Have you been hospitalized or had a serious illness within the past five years? ☐ Yes ☐ No

Explain _____

Have you been treated now or in past with Bisphosphonates for Osteoporosis or cancer? ☐ Yes ☐ No

Explain _____

Are you Pregnant or is it likely that you could be pregnant at this time? ☐ Yes ☐ No

Explain _____

Do you?

☐ Smoke Packs per day?_____ How long?_____

☐ Chew Tobacco

☐ Drink Per week? _____ Per Month?_____

☐ Wear Contact Lenses

☐ Take Diet Pills

☐ Take Herbal Supplements

Circle if you have or ever had

Y	N	Artificial Limb/joint/hip	Y	N	Chronic Diarrhea
Y	N	High/low Blood Pressure	Y	N	Stoke TIA
Y	N	Organ Transplant	Y	N	Joint Surgery
Y	N	Sinus Problems	Y	N	Cancer/Chemotherapy
Y	N	Migraines	Y	N	Blood Disorder
Y	N	Frequent Headaches	Y	N	Increased Frequent Urination
Y	N	Claustrophobia			
Y	N	Artificial Heart Valve	Y	N	Bells Palsy
Y	N	Prolonged Bleeding	Y	N	Heart Disease
Y	N	Ulcers/colitis	Y	N	Diabetes
Y	N	Hay Fever	Y	N	Asthma
Y	N	Head injury	Y	N	Night Sweat
Y	N	Venereal Disease	Y	N	Psychiatric/Emotional
Y	N	Mitral Valve Prolapse	Y	N	Recurrent Infections
Y	N	Acid Reflux	Y	N	Angina
Y	N	Arthritis	Y	N	Kidney Problems
Y	N	Epilepsy/seizures	Y	N	Bronchitis
Y	N	STD	Y	N	Addictions
Y	N	Rheumatic Fever	Y	N	Pace Maker
Y	N	Radiation Therapy	Y	N	Liver Problems
Y	N	Stomach Problems	Y	N	Emphysema
Y	N	Glaucoma	Y	N	TMJ Problems
Y	N	Dizziness/Fainting spells	Y	N	Shortness of Breath
Y	N	Treated for AIDS,HIV, ARC	Y	N	Hepatitis: A or B or C
Y	N	Heart Murmur	Y	N	Tuberculosis
Y	N	Thyroid Problems	Y	N	Unexplained Weight Loss
Y	N	Used Diet Drug Fen-Phen	Y	N	Mouth Ulcers
Y	N	Anemia	Y	N	Aspirin Daily

Please mark any allergies/adverse reactions :

Y	N	Penicillin	Y	N	Aspirin
Y	N	Tetracycline	Y	N	Valium
Y	N	Erythromycin	Y	N	Barbiturates
Y	N	Sulfa	Y	N	Latex
Y	N	Local Anesthetics	Y	N	Iodine
Y	N	Codeine	Y	N	Household Bleach
Y	N	NSAID (Advil/Motrin)			
Y	N	Gluten	Other _____		

_____ _____

Patient or Responsible Party Signature Date

_____ _____

Dentist Signature Date