We warmly welcome you to our office. Please take a few moments to complete the following information so that we can better care for you. It is our goal to help you reach and maintain maximum oral health.

Circle one: Mr. Mrs. Dr. Ms. Miss

Name: _____

I prefer to be called:_____ Male Female

Birth date: _____ SSN:_____

Home address:_____

_____

Hm # _____ Cell #_____

Wk # _____ Pgr # _____

Email _____

How do you prefer to confirm your appointments?

_____

Employer: _____

_____

Occupation: _____

Whom may we thank for referring you? _____

Other family members seen by us?

_____

Previous / Present Dentist: _____

Date of Last Visit : _____ Ph# _____

Physician's Name: _____

Phone: _____

Address: _____

Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Address: _____

Phone: _____

Group # (Plan, Local, or Policy #) _____

Insured's Name: _____

Relation: _____

Insured's Birth date: _____

Insured's SSN: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Address: _____

Phone: _____

Group # (Plan, Local, or Policy #) _____

Insured's Name: _____

Relation: _____

Insured's Birth date: _____

Insured's SSN: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name:_____

Relation:_____

Wk # _____ Hm # _____

A note for patients with dental insurance – We will assist you to maximize your insurance benefits, and we are happy to file claims to your insurance carrier and agree to accept payment from any carrier that offers an assignment of benefits, if you desire. We will do our best to calculate your available benefit amount, however, regardless of what your insurance plan pays, you are responsible for all fees.

Medical History

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

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

If yes, please explain: _____

Are you taking any prescription/over the counter drugs? ☐ Yes ☐ No

If yes, please list: _____

Do you use or smoke tobacco in any form? ☐ Yes ☐ No

Have you or do you take medication for osteoporosis? ☐ Yes ☐ No

For women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No week# _____

Have you ever had head or neck trauma? Yes No

Do you wear a night guard? Yes No

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Herpes/Fever Blisters
Y	N	Alcohol/Drug Abuse	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	HIV+/AIDS
Y	N	Angina Pectoris	Y	N	Hospitalized Any Reason
Y	N	Arthritis	Y	N	Kidney Problems
Y	N	Artificial Bones/Joints/Valves	Y	N	Latex Allergy
Y	N	Asthma	Y	N	Liver Disease
Y	N	Blood Transfusions	Y	N	Low Blood Pressure
Y	N	Cancer/Chemotherapy	Y	N	Mitral Valve Prolapse
Y	N	Colitis	Y	N	Nervous/Anxious
Y	N	Congenital Heart Defect	Y	N	Pacemaker
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Emphysema	Y	N	Rheumatic/Scarlet Fever
Y	N	Epilepsy	Y	N	Seizures
Y	N	Fainting Spells	Y	N	Shingles
Y	N	Frequent Headaches	Y	N	Sinus Problems
Y	N	Glaucoma	Y	N	Stroke
Y	N	Hay Fever	Y	N	Thyroid Problems
Y	N	Heart Attack	Y	N	Tumors
Y	N	Heart Murmur	Y	N	Ulcers
Y	N	Heart Surgery	Y	N	Venereal Disease
Y	N	Hemophilia	Y	N	Yellow Jaundice
Y	N	Hepatitis			

Do you have, or have you had any disease, condition, or problem not listed above?:

_____

_____

Are you allergic to any of the following items?

Y	N	Aspirin	Y	N	Latex
Y	N	Codeine	Y	N	Penicillin
Y	N	Dental Anesthetics	Y	N	Tetracycline
Y	N	Erythromycin	Y	N	Other

Please list any other drugs you are allergic to:

Dental History

Why have you come to the dentist today? _____

_____

Are your teeth sensitive to: ☐ Heat ☐ Cold ☐ Pressure ☐ Sweets

Do you have any fear of dental work? ☐ Yes ☐ No

Have you been diagnosed with sleep apena? Yes No

_____

How do you feel about the appearance of your teeth? _____

_____

How would you describe the condition of your teeth and gums?

☐ Good ☐ Fair ☐ Poor

Are you currently in pain or discomfort with your teeth or gums?

☐ Yes ☐ No If yes, please explain: _____

How often do you brush your teeth? _____ Floss? _____

Do your gums bleed when you brush? ☐ Yes ☐ No

Do your gums bleed when you floss? ☐ Yes ☐ No

Have you ever experienced pain in you jaw joint? ☐ Yes ☐ No

Have you ever been treated for TMJ symptoms? ☐ Yes ☐ No

If yes, please explain: _____

Do you grind or clench your teeth? ☐ Yes ☐ No

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me, and to use the appropriate medication and therapy indicated for such treatment in connection with the patient named on this form. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1½ % finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be ordered.
5. I understand that it is my responsibility to advise your office of any changes in the information obtained.
6. I authorize the use of my social security number to file my dental claims.

Medical History/Consent

*Signature*_____ *Date* _____

*Signature*_____ *Date* _____

*Signature*_____ *Date* _____