

Welcome

Thank you for selecting our dental healthcare team!

We will strive to provide you with the best possible dental care. To help us meet all of 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.

Patient Information (Confidential)

Date _____

Full Name _____ Birthdate _____ Soc. Sec. # _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 Check Appropriate Box: Minor Single Married Divorced Widowed Sex: Male Female E-mail Address _____
 If patient is a minor: Mom's Name _____ Dad's Name _____

Whom May We Thank For Referring You? _____
 Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Same as Patient Information? Yes or No IF NO, COMPLETE THIS SECTION:

Name of Person Responsible for this Account _____ Relationship to Patient _____
 Address _____ City _____ State _____ Zip _____
 Birthdate _____ Soc. Sec. # _____ Home Phone _____ Work Phone _____
 Employer _____ Is this Person Currently a Patient in Our office? Yes No

Insurance Information

Name of Insured _____ Relationship to Patient _____
 Birthdate _____ Soc. Sec. # _____ Insurance Effective Date _____
 Name of Employer _____ Work Phone _____
 Address of Employer _____ City _____ State _____ Zip _____
 Insurance Company _____ Group # _____ I.D./Policy # _____
 Ins. Address _____ City _____ State _____ Zip _____
 Ins. Phone # _____
 How Much is your Deductible? _____ What is your Max. Annual Benefit? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE ? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
 Birthdate _____ Soc. Sec. # _____ Insurance Effective Date _____
 Name of Employer _____ Work Phone _____
 Address of Employer _____ City _____ State _____ Zip _____
 Insurance Company _____ Group # _____ I.D./Policy # _____
 Ins. Address _____ City _____ State _____ Zip _____
 How Much is your Deductible? _____ What is your Max. Annual Benefit? _____

Medical History Updates (To be filled out at future dental appointments)

Has there been any change since your last dental appointment?

Date	Changes in health	Initials
_____	_____	_____
_____	_____	_____
_____	_____	_____

DENTAL HISTORY

Please check any of the following problems that apply to you.

- Sensitivity (hot, cold, sweet)
- Where? UR LR UL LL
- Headaches, earaches, neck pain
- Jaw joint pain
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen or irritated gums
- Loose, tipped or shifting teeth
- Bad breath

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

- Dentures
- Partial dentures
- Braces
- Periodontal (gum) treatments

Please share the following dates:

- Your last cleaning / /
- Your last oral cancer screening / /
- Your last complete X-Rays / /

Name of Previous Dentist _____

City _____ **State** _____

Phone Number _____

What is the most important thing to you about your future smile and dental health? _____

If you could whiten your teeth for a cost anyone could afford, would you do it?

Do you smoke or use chewing tobacco?
How Much? _____ For how long? _____

If I could change my smile, I would:

- Make them whiter
- Make them straighter
- Close spaces
- Replace black metal fillings with tooth colored restorations
- Repair chipped teeth
- Repair missing teeth
- Replace old crowns that don't match
- Have a smile makeover

On a scale of 1-10, with 10 being the highest rating:

-How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

-Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

-Where do you want your dental health to be?
1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist? _____

What is the most important thing to you about your dental visit today? _____

MEDICAL HISTORY

Please check any of the following that apply to you:

- | | |
|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Allergies (Seasonal) | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Conditions |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Lesions (Congenital) |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Heart Surgery |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure |

- | | |
|---|---|
| <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Jaw Joint Pain | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Metal | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Nervousness/Depression | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Phen Fen (1 month +) | <input type="checkbox"/> Venereal Diseases |
| <input type="checkbox"/> Pregnant Currently | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Radiation (head/neck) | |

Do you have any of the following allergies?

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Vicodin | <input type="checkbox"/> Erythromycin |
| <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Valium |
| <input type="checkbox"/> Sulfa | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Latex | |

Family Physician _____ **Phone Number** _____

Are you under a physician's care? What for? _____

Are you taking any medications? What? _____

Have you ever had to premedicate before any dental visits due to: Heart Murmur, Joint Replacement, Rheumatic Fever?

Yes _____ No _____?

***If yes, what type of premedication?** _____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: _____ **Dental Personnel Initials:** _____