Welcome! Thank you for selecting our dental team! We will strive to provide you with the best possible dental care. So that we can better assist you with your dental needs, please take a few moments to answer the following questions.

Patient Information

Date ______________________________ Birthdate ______________________

Name ______________________________ I prefer to be called ______________________

Male Female Single Married ☐ Divorced Widowed

Address ____

City State Zip Code

Home Phone _________________________ May we leave a message? Yes No

Cell Phone _________________________ May we leave a message? Yes No

Work Phone _________________________ May we leave a message? Yes No

Email Address ________________________________

May we e-mail appointment reminders? ☐ Yes No May we e-mail monthly newsletter? Yes No

Whom may we thank for referring you? ____

Person to contact in case of emergency: _________________________ Phone _________________

Responsible Party

If Patient is under age 18, please list RESPONSIBLE PARTY information below:

Person Responsible for Account _________________________ Relationship to Patient ___________

Responsible Party's Address ____

Home Phone ______________ Cell Phone _________________ Email _______________________

Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance Information

Our office does not take insurance for payment, but we will submit your claim.

Name of Insured ____________________________ Relationship to Patient ______________

Insured's Birthdate ____________________________ Insured's SS# ______________

Name of Employer ___________________ Union or Local # _____ Work Phone ___________

Insurance Co. Name ___________________ Group # ___________ Policy ID# ___________

Insurance Co. Address ____

Secondary Insurance

– see next page.

Secondary Insurance

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

Name of Insured ______________________ Relationship to Patient ____________

Insured's Birthdate ______________________ Insured's SS# ____________

Name of Employer ________________ Union or Local # _____ Work Phone __________

Insurance Co. Name ________________ Group # __________ Policy ID# __________

Insurance Co. Address ____

Patient Medical History

Physician ____________________ Office Phone __________ Date of Last Exam __________

	Yes	No
1. Are you under medical treatment now?		
2. Have you ever had a serious illness or surgical operation w/in the last 5 years? Please explain: ______________		
3. Are you taking any medications? Please list: ________________ ________________		
4. Do you smoke?		
5. Do you use controlled substances?		
6. Women only: Are you pregnant?		
Are you nursing?		
Are you taking birth control pills?		

	Yes	No
7. Have you had allergic reactions to:		
Local anesthetics (e.g., Novocain)		
Penicillin or other antibiotics		
Sulfa Drugs		
Barbiturates (sleeping pills)		
Sedatives		
Iodine		
Aspirin		
Any metals (mercury, nickel, etc.)		
Latex rubber		
Other: ________________ ________________		

Do you have, or have you had, any of the following? Please check all that apply:

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 valve prolapse
Thyroid Problem	Stomach troubles / ulcers	Other: ____________

Patient Dental History

Name of Previous Dentist and Location ______________________________ Date of Last Exam ___________

Are you experiencing any of the following? Please check all that apply:

☐ Bad breath	☐ Loose teeth or broken fillings	☐ Sensitivity to sweet liquids/foods
☐ Bleeding gums	☐ Orthodontic treatment	☐ Sensitivity to sour liquids/foods
☐ Blisters/lumps on lips or mouth	☐ Pain around ear	☐ Frequent headaches
☐ Fingernail biting	☐ Periodontal treatment	☐ Jaw, head, or neck injury
☐ Clenching or grinding teeth	☐ Sensitivity to cold	☐ Jaw difficult to open or close
☐ Lip or cheek biting	☐ Sensitivity to heat	☐ Difficulty chewing
☐ Clicking in the jaw	☐ Tooth Pain	☐ Other: ____________________

Have you ever had any difficult tooth extractions in the past? Yes No

Have you ever had any prolonged bleeding following tooth extractions? Yes No

Do you wear dentures or partials? Yes ☐No If yes, date of placement: ____________________

Have you ever had a root canal? Yes No If yes, when and how many? ____________________

Do you have any mercury fillings? Yes ☐No If yes, how many? ____________________

Authorization and Release

I affirm that the information I have given is correct to the best of my knowledge. I understand that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

Signature ____ Date ______________

PAYMENT IS DUE AT THE TIME OF SERVICE