Patient Information

First Name Middle Last

You are:

- ☐ Policy Holder
- ☐ Responsible Party

Whom may we thank for referring you to us? _____

Patient Information

Address: _____ Apt/Number: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Ext. _____
Sex: ☐ Male ☐ Female
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed
Birthdate: _____ Age: _____ Social Security #: _____
Email address: _____
☐ I would like to receive correspondence via email

Responsible Party (if other than the patient)

Address: _____ Apt/Number: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Ext. _____
Birth date: _____ Social Security #: _____
☐ Responsible party is also a policy holder:
☐ Primary policy holder
☐ Secondary policy holder

Primary Insurance Information

Name of insured: _____
Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____
Employer: _____
Employer Address: _____ Number: _____
City: _____ State: _____ Zip: _____
Insurance Company: _____
Insurance Co. Address: _____ Number: _____
City: _____ State: _____ Zip: _____
Rem. Benefits: $_____.00 Rem. Deduct: $_____.00

Secondary Insurance Information

Name of insured: _____
Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____
Employer: _____
Employer Address: _____ Number: _____
City: _____ State: _____ Zip: _____
Insurance Company: _____
Insurance Co. Address: _____ Number: _____
City: _____ State: _____ Zip: _____
Rem. Benefits: $_____.00 Rem. Deduct: $_____.00

Emergency Contact Information

Name: _____ Relationship: _____
Address: _____ Apt/Number: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Ext. _____

Dental History

First Name Middle Last

Previous Dentist: _____ City: _____
Date of last exam: _____ Date of last cleaning: _____
What prompted you to seek dental care at this time? _____
_____

How do you clean your teeth? Please check as appropriate:

Brush texture: ☐ Soft ☐ Medium ☐ Hard

Brushing: ☐ 1 ☐ 2 ☐ 3 times ☐ per day ☐ per week ☐ per month

Flossing: ☐ 1 ☐ 2 ☐ 3 times ☐ per day ☐ per week ☐ per month

Do you use any of the following: ☐ Toothpicks ☐ Salt ☐ Soda ☐ Mouth Rinses ☐ WaterPik ☐ Peroxide

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

☐ Aching or sensitive teeth	☐ Breathing problems	☐ Orthodontic treatment	☐ Broken fillings
☐ Areas where food traps	☐ Swollen glands	☐ Trouble opening wide	☐ Loose teeth
☐ Sensitive or bleeding gums	☐ Broken or missing teeth	☐ Pain near the ear	☐ Fever sores
☐ Difficulty swallowing	☐ Grinding your teeth	☐ Gum infection	☐ Dry mouth

If you could change your smile, what would you change?

☐ Straight or even front teeth ☐ Gums receding from teeth ☐ Discolored front fillings ☐ Teeth all the same color ☐ Unsightly fillings in back teeth ☐ Other: _____
_____

For each of the following questions, select the number under the word or phrase that best describes your feelings.					
	Relaxed	A Little Uneasy	Tense	Anxious	Very Anxious
If you had to go to the dentist tomorrow, how would you feel about it?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Imagine you are waiting in the dentist's office for your turn in the chair. How do you feel?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Imagine you are sitting in the dentist's chair as she prepares to give you a shot. How do you feel?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Imagine you are waiting in the hygienist's chair and he/she is getting the instruments used to scrape your teeth. How do you feel?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

The undersigned hereby authorizes the doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in the connections with (name of patient) _____ and further authorize and consent that the doctor choose and employ such assistance as she deems fit. I understand that the use of anesthetic agents and certain treatments embody some risk. In good faith, the doctor will present these risks and alternatives to proposed treatment and my questions will have been answered in order to proceed in an informed fashion.

I understand that responsibility for payment for dental services provided in the office for myself or my dependents is mine, and arrangements for payment will be made before initial treatment begins. Breach of this responsibility carries the penalty of compensating the doctor(s) for attorney's and collection fees. I also understand that, where appropriate, credit bureau reports may be obtained.

_____
Signature of Patient Date

_____
Signature of Parent of Responsible Person (Relationship) Date

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication which you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Medical History

First Name Middle Last

Please explain any "yes" answers below:

Are you under a physician's care now? ☐ Yes ☐ No _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No _____

Are you taking any medication, pills, or drugs? ☐ Yes ☐ No _____

_____

_____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No _____

Do you use tobacco? ☐ Yes ☐ No _____

Are you on a special diet? ☐ Yes ☐ No _____

Do you use controlled substances? ☐ Yes ☐ No _____

Have you ever taken Bisphosphonate drugs (Boniva, Fosamax)? ☐ Yes ☐ No _____

Women: Are you ☐ Pregnant/trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ SULFA ☐ Other_____

Do you have, or have you had, any of the following?				
☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heat Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur*	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Pace Maker*	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumor or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever*	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

*Condition may require medication

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

Comments: _____

_____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian Date