We are pleased to welcome you to our practice.
Please take a few minutes to fill out this form as completely as you can.
If you have questions we'll be glad to help you.
We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

NAME: _____ Soc. Sec. # _____
Last Name First Name M.I.

HOME ADDRESS: _____ CITY _____ STATE _____ ZIP _____

CELL PHONE _____ HOME PHONE _____ EMAIL _____

SEX☐M ☐ F Age: _____ Birthdate:_____ ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐Separated

IF STUDENT, NAME OF SCHOOL/COLLAGE:_____CITY:_____STATE: _____☐ Full Time ☐ Part Time

PATIENT OR PARENT/GUARDIAN'S EMPLOYER: _____WORK PHONE: _____

BUSINESS ADDRESS: _____BUSINESS PHONE: _____

WHO MAY WE THANK FOR REFERRING YOU?_____☐Website ☐Google ☐Bing ☐Yahoo ☐Yelp ☐ Magazine

PERSON TO CONTACT IN CASE OF EMERGENCY _____ PHONE _____

PRIMARY DENTAL INSURANCE INFORMATION:

PERSON RESPONSIBLE FOR ACCOUNT _____
Last Name First Name

RELATION TO PATIENT_____ BIRTHDATE_____ Soc. Sec. #_____

ADDRESS (if different from patient) _____CITY _____STATE _____ ZIP _____

CELL PHONE _____HOME PHONE_____ EMAIL_____

PERSON RESPONSIBLE EMPLOYED BY _____OCCUPATION_____

BUSSINESS ADDRESS_____BUSSINESS PHONE _____

INSURANCE COMPANY _____GROUP ID#_____ SUBSCRIBER ID#_____

DO YOU HAVE ANY ADDITIONAL INSURANCE_____ ☐YES ☐NO IF YES, COMPLETE THE FOLLOWING:

SECONDARY DENTAL INSURANCE INFORMATION:

SUBSCRIBER NAME_____ RELATION TO PATIENT_____ BIRTHDATE_____
Last name First name

ADDRESS (if different from patient) _____CITY _____ STATE _____ ZIP _____

CELL PHONE _____ HOME PHONE_____ EMAIL_____

BUSSINESS ADDRESS_____ BUSSINESS PHONE _____

INSURANCE COMPANY _____GROUP ID#_____ SUBSCRIBER ID #_____

DENTAL HISTORY QUESTIONNAIRE

□What is the reason for your visit today?
___ Checkup
___ Tooth ache
___ Teeth or gums hurting or bothering me
___ Other _____
□When was the last time you were seen by a dentist for a cleaning? _____
□When was the last time you were seen by a dentist for a complete dental exam? _____
□How often do you have dental examinations?
___Twice per year
___Once per year
___Every few years
___More than 3 years between exams
□How many times a day do you brush your teeth? _____ How many times a day do you floss? _____
□What type of toothbrush do you use? ___ Manual ___ Electric ___ Both
□Do you wear removable dentures or partial dentures? ___ Yes ___ No
If you wear dentures or partial dentures, when were they placed? _____
□Are you using any other dental devices (i.e. retainer, bite guard, snoring appliance, etc.?)___ Yes ___ No
If yes, please describe: _____
□ Do you have any dental problems now or feel pain to any of your teeth? ___ Yes ___ No
If yes, please describe: _____
□Are your teeth sensitive to any of the following: ___ Hot/Cold? ___ Sweets ___ Biting/Chewing
□ Do you have any sores or lumps in or near your mouth? ___ Yes ___ No
□ Do your gums bleed while brushing for flossing? ___ Yes ___ No ___ Sometimes
□ Does food tends to become caught in between your teeth? ___ Yes ___ No
□ Do you clench or grind your teeth? ___ Yes ___ No ___ Unsure
□ Do you bite your lips or cheeks frequently? ___ Yes ___ No
□ Do you hold foreign objects with your teeth (pencils, pipes, nails, fingernails, etc.)? ___ Yes ___ No
□ Do you have tired jaws, especially in the morning? ___ Yes ___ No
□ Do you smoke or use tobacco? ___ Yes ___ No
□ Have you ever had orthodontic treatment (i.e. braces, retainer, etc.)? ___ Yes ___ No
□ Have you ever had any of the following? (If yes, please describe.):
___ Oral Surgery_____
___ Periodontal Treatment_____
___ Your bite adjusted_____
___ A Night Guard_____
___ A serious injury to the mouth or head
□ Have you ever experienced any of the following?
___ Clicking or popping of the jaw
___ Pain in joint, ear, side of face
___ Difficulty opening or closing the mouth
___ Difficulty chewing on either side of the mouth
___ Headaches, neckaches, or shoulder aches
___ Sore muscles (neck, shoulders)
□ Have you ever had prolonged bleeding following an extraction? ___ Yes ___ No
□ Are you interested in doing cosmetic treatment (i.e. whitening, veneers, straightening teeth, changing your smile)?
_____ Yes _____No
□ Do you like your smile? ___ Yes ___ No
□ Is there anything else about having dental treatment that you would like us to know? ___ Yes ___ No
If yes, please describe: _____

MEDICAL HISTORY QUESTIONNAIRE

□ What is the approximate date of your last doctor's visit? _____
□ Name and phone number of your physician: _____
□ Are you under medical treatment now? ___ Yes ___ No
If yes, please describe: _____
□ Are you taking any medications, including non-prescription medications? ___ Yes ___ No
If yes, please list them below:

_____

□ Have you ever taken prescription medications for weight loss? ___ Yes ___ No
If yes, did you take any of the following? ___ Fen-Phen (Fenfluramine-Phentermine)
___ Pondimen (Fenfluramine)
___ Redux (Dexfenfluramine)
___ Other_____

□ Do you have a persistent cough or throat clearing not associated with a known illness, lasting more than three weeks?_ Yes ___No

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

___ High Blood Pressure	___ Hay Fever/Allergies	___ Emphysema
___ Arthritis	___ Abnormal Blood Conditions (Hemophilia)	___ Cancer
___ Stomach Problems (ulcers, colitis, etc.)	___ Heart Murmur	___ Hepatitis/Jaundice
___ Low Blood Pressure	___ Thyroid Problems	___ Glaucoma
___ Swollen Ankles	___ AIDS or HIV	___ Chemotherapy
___ Fainting/Loss of Consciousness	___ Angina	___ STDs
___ Heart Attack	___ Diabetes	___ Tuberculosis
___ Joint Replacement	___ Leukemia	___ Radiation Therapy
___ Epilepsy/Seizures	___ Chest Pains	___ Recent Weight Loss
___ Rheumatic Fever	___ Kidney Diseases	___ Mitral Valve Prolapse
___ Respiratory Problems	___ Anemia	___ Drug or Alcohol Abuse
___ Easily Winded	___ Stroke	___ Psychological Disorders
___ Heart Disease	___ Liver Disease	___Other_____
___ Asthma	___ Pacemaker	_____
___ Frequently Tired		

□ Are you allergic to, or have you had any reactions to the following?:

___ Local Anesthetics (i.e. Novocaine)	___ Other Antibiotics (i.e. Erythromycin, Tetracycline)
___ Codeine	___ Latex Rubber
___ Sedatives	___ Aspirin
___ Sulfa Drugs	___ Any Metals (Nickel, Mercury, etc.)
___ Penicillin or Amoxicillin	___ Food Allergies
___ Barbiturates	___ Other_____

□ Do you have frequent headaches? ___ Yes ___ No □ Are you wearing contact lenses? ___ Yes ___ No

□ ***Women only:***
Are you pregnant or do you think you may be pregnant? ___ Yes ___ No
If you are pregnant, how many weeks? _____ Are you nursing? ___ Yes ___ No
Are you taking oral contraceptives (birth control pills)? ___ Yes ___ No

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□ I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such medical care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature: _____ Date: _____