# Welcome
## To Our Practice

**Please take a few minutes to answer the following questions so we can better assist you with your dental needs**

## PATIENT INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____ Home Phone _____
Last Name First Name Initial

Address _____ Cell Phone _____

City _____ State _____ Zip _____ E-mail _____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

## PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

## ADDITIONAL INSURANCE (IF APPLICABLE)

Insured Name _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

**PLEASE COMPLETE REVERSE SIDE**

## Dental History

Former Dentist _____ Date of Last X-Rays _____

City, State _____ How Often Do You Floss? _____

Date of Last Dental Visit _____ How Often Do You Brush? _____

Please check all that apply:

- Bad Breath ☐
- Bleeding Gums ☐
- Blisters on Lips or Mouth ☐
- Finger Nail Biting ☐
- Grinding Teeth ☐
- Lip or Cheek Biting ☐
- Loose Teeth or Broken Fillings ☐
- Orthodontic Treatment ☐
- Pain Around Ear ☐
- Periodontal Treatment ☐
- Sensitivity to Cold ☐
- Sensitivity to Heat ☐
- Sensitivity to Sweets ☐
- Sensitivity When Biting ☐
- Frequent Headaches ☐
- Jaw, Head or Neck Injuries ☐
- Jaw Difficulty: Clicking and/or Pain ☐
- Tooth Pain ☐

## Medical History

Physician's Name _____ Date of Last Visit _____

| | Yes | No |
|---|---|---|
| 1. Are you currently under medical treatment? | ☐ | ☐ |
| 2. Have you ever had any serious illnesses or operations? | ☐ | ☐ |
| 3. Are you currently taking any medication? | ☐ | ☐ |
| Please describe: _____ | | |
| 4. Do you smoke? | ☐ | ☐ |
| 5. Do you use alcohol, cocaine or other drugs? | ☐ | ☐ |
| 6. Do you wear contact lenses? | ☐ | ☐ |

7. Have you had any allergic reactions to the following:

| | Yes | No |
|---|---|---|
| Local Anesthetics (eg. novocaine) | ☐ | ☐ |
| Penicillin or other Antibiotics | ☐ | ☐ |
| Sulfa Drugs | ☐ | ☐ |
| Barbiturates (sleeping pills) | ☐ | ☐ |
| Sedatives | ☐ | ☐ |
| Iodine | ☐ | ☐ |
| Aspirin | ☐ | ☐ |
| Other | ☐ | ☐ |

8. (Women Only) Are You:

| | | |
|---|---|---|
| Pregnant? | ☐ | ☐ |
| Nursing? | ☐ | ☐ |
| Taking birth control pills? | ☐ | ☐ |

Please check all that apply:

- AIDS ☐
- Anemia ☐
- Arthritis, Rheumatism ☐
- Artificial Heart Valves ☐
- Artificial Joints ☐
- Asthma ☐
- Back Problems ☐
- Bleeding abnormally, with extractions or surgery ☐
- Blood Disease ☐
- Cancer ☐
- Chemical Dependency ☐
- Chemotherapy ☐
- Chronic Fatigue Syndrome ☐
- Circulatory Problems ☐
- Congenital Heart Lesions ☐
- Cortisone Treatments ☐
- Cough - persistent or bloody ☐
- Diabetes ☐
- Emphysema ☐
- Epilepsy ☐
- Fainting or Dizziness ☐
- Glaucoma ☐
- Headaches ☐
- Heart Murmur ☐
- Heart Problems ☐
- Hepatitis-Type _____ ☐
- Herpes ☐
- High Blood Pressure ☐
- HIV Positive ☐
- Jaundice ☐
- Jaw Pain ☐
- Kidney Disease ☐
- Latex Sensitivity ☐
- Liver Disease ☐
- Low Blood Pressure ☐
- Mitral Valve Prolapse ☐
- Nervous Problems ☐
- Pacemaker ☐
- Psychiatric Care ☐
- Radiation Treatment ☐
- Respiratory Disease ☐
- Rheumatic Fever ☐
- Scarlet Fever ☐
- Shortness of Breath ☐
- Sinus Trouble ☐
- Skin Rash ☐
- Stroke ☐
- Swelling of Feet/Ankles ☐
- Swollen Neck Glands ☐
- Thyroid Problems ☐
- Tonsillitis ☐
- Tuberculosis ☐
- Tumor or growth on head/neck ☐
- Ulcer ☐
- Venereal Disease ☐

## Assignment and Release

I hereby authorize payment directly to Dr. Wilfred Charles for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

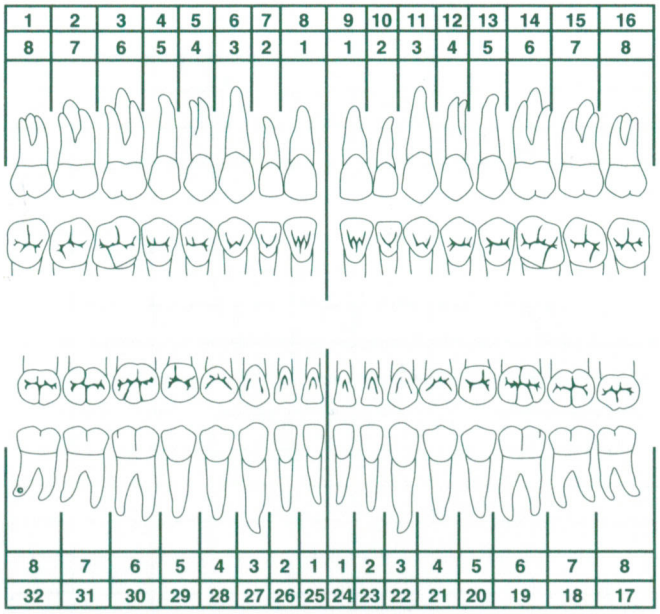
Signature of Responsible Party _____ Date _____

# EXAMINATION RECORD

Last Name | First name | Tel. no. | Referred (to or) by Dr. | Patient number

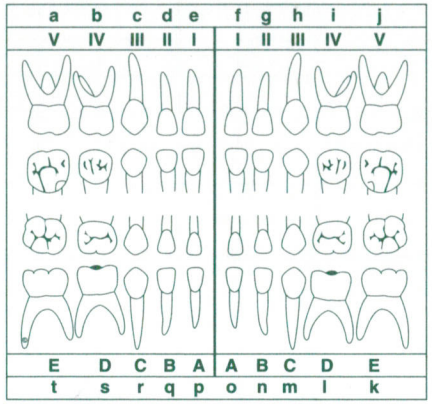
Address | Recommended by | Date

City | State | Zip | Address










## GENERAL HEALTH HISTORY

Last physical examination _____ Weight _____ Birth date _____

Are you under the care of a physician now _____ Name _____ Telephone no _____

For what reason _____

Are you receiving medication now _____ What _____ Do you have excessive bleeding from a cut _____

Do you have or have you had—

☐ Anemia _____ ☐ Sinusitis _____ ☐ Radiation treatment _____ ☐ Allergies to food _____

☐ Diabetes _____ ☐ Rheumatic fever _____ ☐ Vincents (trench mouth) _____ ☐ Additional _____

☐ Arthritis _____ ☐ Abnormal blood pressure _____ ☐ Hepatitis _____ ☐ Ulcer _____

☐ Abnormal heart condition _____ ☐ Tuberculosis _____ ☐ Other _____ ☐ Other _____

## DENTAL HISTORY

Are you having any discomfort at this time _____ How long since you have been to a dentist _____

What was done then _____ Did you have X-rays _____ Did you make regular visits to the dentist before then _____

Have you lost any teeth _____ Why _____ Any complications with extractions _____

Have they ever been replaced by: (1) A fixed bridge _____ (2) Removable partial _____ (3) Denture _____

If yes to (2) or (3): How many _____ Why _____

How do you feel about your teeth _____

How do you feel about dentures _____

Are your teeth sensitive to heat _____ To cold _____ To sweets _____ To acids _____ Have you had your teeth straightened _____

When _____ How often do you brush your teeth _____ When _____ How _____

What type brush do you use _____ Do you use dental floss _____ Between-the-teeth stimulator _____ Water jet _____

Do you have bleeding gums _____ When _____ Do you eat between meals _____

Do you brush your teeth then _____ Do you have food impaction _____ Where _____

Do you grind or clench your teeth _____ When _____ Have you ever had periodontal treatment _____

When _____ Do you have offensive breath _____ Unpleasant taste in mouth _____ Are you allergic to novocaine _____

To antibiotics _____

School _____ Grade _____

Tonsils _____ Adenoids _____

Diseases—measles _____ Chickenpox _____

Scarlet fever _____ Whooping cough _____

Mumps _____ Other _____

Habits—thumb or finger sucking _____ Posture _____

Mouth breathing _____ Tongue _____

Reaction to dentistry _____

X-rays _____

Date _____

Study model _____

Photograph _____

Transillumination Area _____

## CLINICAL DATA

General condition of teeth _____ Condition of mucosa _____ Inflammation of gingival tissue _____

Moderate _____ Severe _____ Color _____ Any recession _____ Area _____

Calculus: Slight _____ Moderate _____ Excessive _____ Oral cancer exam _____

Occlusion: _____