

Thank you for selecting us.

To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

Welcome

Patient Information (Confidential)

Name _____ Patient Number _____

Date _____

SS#/SIN _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Email _____ Cell Phone _____

Check Appropriate Box: Minor Single Married Separated Divorced Widowed

If Student, Name of School/College _____ City _____ State/Prov. _____ Full Time Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this Person Currently a Patient in our Office? Yes No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

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

Employer Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Do You Have Any Additional Insurance? Yes No If Yes, Complete the Following

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

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

Employer Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

1. Are you under medical treatment now?	Yes <input type="checkbox"/> No <input type="checkbox"/>	10. Are you wearing contact lenses?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	11. Are you allergic to or have you had any reactions to the following?	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	Local Anesthetics (e.g. Novocain)	<input type="checkbox"/>
4. Have you ever taken Fen-Phen/Redux?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Penicillin or any other Antibiotics	<input type="checkbox"/>
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sulfa Drugs	<input type="checkbox"/>
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Barbiturates	<input type="checkbox"/>
7. Do you use tobacco?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sedatives	<input type="checkbox"/>
8. Do you use controlled substances?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Iodine	<input type="checkbox"/>
9. Do you have or have you had any of the following?		Aspirin	<input type="checkbox"/>
High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Any Metals (e.g. nickel, mercury, etc.)	<input type="checkbox"/>
Heart Attack	Yes <input type="checkbox"/> No <input type="checkbox"/>	Latex Rubber	<input type="checkbox"/>
Rheumatic Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other _____	<input type="checkbox"/>
Swollen Ankles	Yes <input type="checkbox"/> No <input type="checkbox"/>	12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Fainting/Seizures	Yes <input type="checkbox"/> No <input type="checkbox"/>	13. Women Only:	
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you pregnant or think you may be pregnant?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Low Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you nursing?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Epilepsy/Convulsions	Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you taking oral contraceptives?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Leukemia	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Kidney Diseases	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cardiac Pacemaker	Yes <input type="checkbox"/> No <input type="checkbox"/>
AIDS or HIV Infection	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Murmur	Yes <input type="checkbox"/> No <input type="checkbox"/>
Thyroid Problem	Yes <input type="checkbox"/> No <input type="checkbox"/>	Angina	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Frequently Tired	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Emphysema	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Joint Replacement or Implant	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Hepatitis/Jaundice	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Sexually Transmitted Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Stomach Troubles/Ulcers	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Chest Pains	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Easily Winded	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Hay Fever/Allergies	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Tuberculosis	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Radiation Therapy	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Glaucoma	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Recent Weight Loss	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Liver Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Heart Trouble	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Respiratory Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Mitral Valve Prolapse	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Other _____	Yes <input type="checkbox"/> No <input type="checkbox"/>

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

1. Do your gums bleed while brushing or flossing?	Yes <input type="checkbox"/> No <input type="checkbox"/>	8. Do you have frequent headaches?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids/foods?	Yes <input type="checkbox"/> No <input type="checkbox"/>	9. Do you clench or grind your teeth?	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/foods?	Yes <input type="checkbox"/> No <input type="checkbox"/>	10. Do you bite your lips or cheeks frequently?	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Do you feel pain to any of your teeth?	Yes <input type="checkbox"/> No <input type="checkbox"/>	11. Have you ever had any difficult extractions in the past?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth?	Yes <input type="checkbox"/> No <input type="checkbox"/>	12. Have you ever had any prolonged bleeding following extractions?	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Have you had any head, neck or jaw injuries?	Yes <input type="checkbox"/> No <input type="checkbox"/>	13. Have you had any orthodontic treatment?	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Have you ever experienced any of the following problems in your jaw?		14. Do you wear dentures or partials? If yes, date of placement _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
Clicking	Yes <input type="checkbox"/> No <input type="checkbox"/>	15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Pain (joint, ear, side of face)	Yes <input type="checkbox"/> No <input type="checkbox"/>	16. Do you like your smile?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Difficulty in opening or closing	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Difficulty in chewing	Yes <input type="checkbox"/> No <input type="checkbox"/>		

Authorization and Release

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 dentist 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 Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly

to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X

Signature of patient (or parent/guardian if minor)

Doctor's Comments _____

Signature _____ Date _____