Dr. Calvin R. White, DDS
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Welcome! Thank you for choosing our dental practice. We strive to provide you with the best possible dental care. In order to help us meet all your dental healthcare needs, please fill out this form completely in ink. Thank you!

Date:_____
SSN:_____

Patient Information (CONFIDENTIAL) *Please circle: Male / Female*

Name:_____Birthdate:_____Home Phone:_____
Address:_____City:_____State_____Zip_____
Email:_____Cell Phone:_____
I would like to receive office info/appointment reminders via: ☐email ☐text ☐phone call (Circle all that apply)
Please check one: ☐ Minor ☐Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Patient or Parent/Guardian's Employer_____Work Phone:_____
Who may we thank for referring you?_____

Emergency Contact:_____Phone:_____ Relationship to Patient:_____

Responsible Party

Name of Person Responsible for this account:_____Relationship to Patient:_____
Address:_____City:_____State:_____Zip_____
Birthdate:_____SSN:_____Home Phone:_____
Email:_____Cell Phone_____
Is this person an active patient in this office? ☐ Yes ☐ No
Please review financial policy and sign. Thank you

Insurance Information

Name of Policy Holder:_____ Relationship to Patient_____
Policy Holder Birthdate_____SSN:_____
DENTAL Insurance Company_____ Policy ID#_____
Ins. Co. Address_____ City_____ State:_____ Zip_____
Policy Holder's Employer_____Phone_____
Employer Address_____ City_____ State:_____ Zip_____

Do you have an additional dental insurance policy? If yes, please complete the following:

Name of Policy Holder:_____ Relationship to patient:_____
Policy Holder Date of Birth:_____SSN:_____
Insurance Company_____Policy ID #_____
Ins. Co. Address:_____City_____State_____Zip_____
Policy Holder's Employer_____Phone:_____
Employer's Address_____City_____State_____Zip_____

Patient Medical History

Physician_____ Office Phone_____Date of Last Exam_____

1. *Are you under medical treatment now?.... ☐ Yes ☐ No*
2. *Have you been hospitalized for any surgical operation Or serious illness in the last 5 years? .. ☐ Yes ☐ No*

Please Explain_____
_____
_____

3. *Are you taking any medications including non-Prescription meds?..... ☐ Yes ☐ No*
   List meds_____

_____
_____

4. *Have you ever taken Fosamax, Boniva, Actonel or any other Cancer medications containing bisphosphonates? ☐ Yes ☐ No*

Please continue to the next page.

7. Do you use tobacco?..... ☐ Yes ☐ No
8. Do you have a persistant cough or throat clearing not associated with a known illness?(Lasting more than 3 weeks?)..... ☐ Yes ☐ No
9. Have you had a joint replacement? If yes, Date:_____
Does this require a PRE-MED?..... ☐ Yes ☐ No
If yes, pre-med you take:_____
10. Are you taking blood thinners? ☐ Yes ☐ No

5. *Have you ever had a serious head, neck, or back injury? ..... ☐ Yes ☐ No*
   Please Explain:_____
6. *Are you allergic or have you had reactions to any of the following?*
   Local Anesthetics(Ex Novocain)..... ☐ Yes ☐ No
   Penicillin or any other antibiotics ... ☐ Yes ☐ No
   Sulfa Drugs..... ☐ Yes ☐ No
   Barbiturates ..... ☐ Yes ☐ No
   Sedatives..... ☐ Yes ☐ No
   Iodine..... ☐ Yes ☐ No
   Aspirin ..... ☐ Yes ☐ No
   Any Metals(nickel,mercury,etc.).. ☐ Yes ☐ No
   Latex Rubber..... ☐ Yes ☐ No
   Other_____
11. *Women ONLY:*
    A) Are you pregnant ?..... ☐ Yes ☐ No
    B) Are you nursing?..... ☐ Yes ☐ No
    C) Are you taking oral contraceptives? ☐ Yes ☐ No

*Have you ever had or do you have any of the following? **PLEASE CIRCLE YES OR NO***

High Blood Pressure...	*Yes*	*No*	*Heart Disease.....*	*Yes*	*No*	*Chest Pains .....*	*Yes*	*No*
Heart Attack/Failure	*Yes*	*No*	*Heart Pacemaker....*	*Yes*	*No*	*Bruise Easily .....*	*Yes*	*No*
Rheumatic Fever.....	*Yes*	*No*	*Heart Murmur.....*	*Yes*	*No*	*Stroke.....*	*Yes*	*No*
Swelling of limbs.....	*Yes*	*No*	*Anemia.....*	*Yes*	*No*	*Tuberculosis.....*	*Yes*	*No*
Asthma.....	*Yes*	*No*	*Emphysema.....*	*Yes*	*No*	*Radiation Therapy..*	*Yes*	*No*
Low Blood Pressure.....	*Yes*	*No*	*Cancer.....*	*Yes*	*No*	*Chemotheraphy.....*	*Yes*	*No*
Epilepsy/Convulsions...	*Yes*	*No*	*Angina.....*	*Yes*	*No*	*Glaucoma .....*	*Yes*	*No*
Leukemia.....	*Yes*	*No*	*Hepatitis/jaundice*	*Yes*	*No*	*Stomach ulcers.....*	*Yes*	*No*
Diabetes.....	*Yes*	*No*	*Liver Disease.....*	*Yes*	*No*	*Thyroid Disease.....*	*Yes*	*No*
High Cholesterol	*Yes*	*No*	*Osteoporosis.....*	*Yes*	*No*	*Psychiatric Care.....*	*Yes*	*No*
Kidney Disease.....	*Yes*	*No*	*Tumors or growths..*	*Yes*	*No*	*Blood Transfusion....*	*Yes*	*No*
Recent Weight Loss.....	*Yes*	*No*	*Lung Disease.....*	*Yes*	*No*	*Blood disease.....*	*Yes*	*No*
Arthiritis	*Yes*	*No*	*Hypoglycemia.....*	*Yes*	*No*	*Excessive Bleeding....*	*Yes*	*No*
Sickle Cell Disease	*Yes*	*No*	*Breathing Problem*	*Yes*	*No*	*Cold Sores/Fever Blisters*	*Yes*	*No*
AIDS or HIV infection....	*Yes*	*No*	*Other:_____*					

Patient Dental History

Name of previous Dentist and Location_____Date of last exam_____

Reason for visit today?_____

Please answer the following. Circle Yes or No

1. *Do your gums bleed while brushing or flossing ? Yes or No*
2. *Are your teeth sensitive to hot/cold liquids? Yes or No*
3. *Are your teeth sensitive to sweet or sour liquids/foods? Yes or No*
4. *Do you feel pain in any of your teeth? Yes or No*
5. *Do you have any sores or lumps in or near your mouth? Yes or No*
6. *Have you had any head, neck, or jaw injuries? Yes or No*
7. *Have you ever experienced any of the following problems in your jaw? Circle any that apply*

   -Clicking -Pain -Difficulty opening or closing -Difficulty chewing

8. *Do you have frequent headaches? Yes or No*
9. *Do you clinch or grind your teeth ? Yes or No*
10. *Do you bite your lips or cheeks frequently ? Yes or No*
11. *Have you ever had any difficult extractions in the past? Yes or No*
12. *Have you ever had any orthodontic treatment? Yes or No*
13. *Do you wear dentures or partials? Yes or No*

    If yes, date if placement_____

Authorization and Release

I certify that I have read and understand the above 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 or my dependent's 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 dependents 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 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_____ Date:_____
Responsible Party (Please Print)

X_____ Date:_____
Responsible Party Signature