Welcome

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

Today's Date_____ Referred By_____

Name_____ I prefer to be called_____
Last Name First Name Middle Initial

Address_____ City_____ Zip_____

Birthdate_____ Single_____ Married_____ Partner_____ Divorced_____ Widowed_____

Phone (H)_____ (W) _____ (Cell) _____

Appointment Confirmations will be sent via text to the cell phone number on file for each patient.

E-Mail Address_____

Employer_____ Occupation_____

Soc. Sec.#_____ Driver's Lic.#_____

EMERGENCY CONTACT

Name_____ Relation_____

Phone (H)_____ (Cell) _____

PRIMARY INSURANCE

Responsible Party_____ Soc. Sec. #_____

Birthdate_____ Relation to Patient_____

Employer_____ Occupation_____

Insurance Carrier_____ Group#_____

SECONDARY INSURANCE

Responsible Party_____ Soc. Sec. #_____

Birthdate_____ Relation to Patient_____

Employer_____ Occupation_____

Insurance Carrier_____ Group#_____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

DENTAL HISTORY

Do you require antibiotics before dental treatment? Yes No
If yes, which medication_____

Do you floss daily? Yes No

Do you brush daily? Yes No

Are you currently in pain ? Yes No

Do you have any sores/lumps near your mouth? Yes No

Are your teeth sensitive to heat, cold, or anything else?
_____

Do you experience problems with your jaw? Yes No

Do you have frequent headaches? Yes No

Have you had orthodontic treatment? Yes No

Do you wear partials or dentures? Yes No

Please list any dental issues or concerns we should be aware of_____

Name of Previous Dentist_____ Date of last visit_____

MEDICAL HISTORY

Physician's Name _____

Date of Last Visit_____

Are you under current medical treatment? Yes No

List any prescription or over the counter drugs you're taking
_____

_____

Do you or have you used Bisphosphonates? Yes No

Do you or have you used controlled substances? Yes No

Do you or have you used tobacco products? Yes No

Are you wearing contact lenses? Yes No

FOR WOMEN:

Are you taking oral contraceptives? Yes No

Are you pregnant/trying? Yes No

Nursing? Yes No

Do you have or have you experienced the following? Please circle either Y or N:

Y N Abnormal Bleeding	Y N Diabetes	Y N Heart Disease	Y N Radiation Treatment
Y N Alcohol Abuse	Y N Difficulty Breathing	Y N Heart Surgery	Y N Recent Weight Loss
Y N Aids/HIV Positive	Y N Difficulty Hearing	Y N Hemophilia	Y N Rheumatic Fever
Y N Anemia	Y N Drug Abuse	Y N Hepatitis	Y N Sleep Apnea
Y N Angina	Y N Dry Mouth	Y N High Blood Pressure	Y N Seizures
Y N Arthritis	Y N Emphysema	Y N High Gag Reflex	Y N STD
Y N Artificial Heart Valve	Y N Epilepsy	Y N Kidney Problems	Y N Shingles
Y N Artificial Joints	Y N Fainting Spells	Y N Leukemia	Y N Sinus Problems
Y N Blood Transfusion	Y N Fever Blisters	Y N Liver Disease	Y N Stomach Troubles
Y N Cancer	Y N Glaucoma	Y N Low Blood Pressure	Y N Stroke
Y N Chemotherapy	Y N Hay Fever/Allergies	Y N Mitral Valve Prolapse	Y N Swollen Ankles
Y N Chest Pains	Y N Headaches	Y N Pacemaker	Y N Thyroid Problems
Y N Congenital Heart Defect	Y N Heart Attack	Y N Persistent Cough	Y N Tonsillitis
Y N Dental Anxiety	Y N Heart Murmur	Y N Psychiatric Problems	Y N Ulcers

Please list any serious medical condition(s) that you have experienced:_____

Are you allergic to any of the following? Please circle either Y or N:

Y N Aspirin	Y N Dental Anesthetics	Y N Penicillin	Y N Tetracycline
Y N Barbiturates	Y N Jewelry / Metals	Y N Sedatives	Y N Other_____
Y N Codeine	Y N Latex	Y N Sulfa Drugs	_____

I affirm the information I have given is correct to the best of my knowledge. I understand providing incorrect information can be dangerous to my health. It will be used by the dentist to help determine appropriate and healthful dental treatment. It is my responsibility to inform this office of any changes in my medical status. I understand I am financially responsible for all charges not paid by insurance. I authorize my insurance company to pay directly to the dentist.

Signature of Patient or Guardian_____ Date_____

Health History Review:

Signature_____ Date_____ Signature_____ Date_____

Signature_____ Date_____ Signature_____ Date_____

Signature_____ Date_____ Signature_____ Date_____

Signature_____ Date_____ Signature_____ Date_____