Date____________

Confidential Patient Information

A B C

Patient's Name____
Last First Middle

Address____
Street City State Zip

Home Phone____________________ Birthdate________________

If patient is a minor, give parent's or guardian's name________________________

Whom may we thank for referring you to our office?________________________

Confidential Responsible Party Information

Name ____
Last First Middle

Marital Status________ Relationship to patient: ❑ Parent ❑ Step-parent ❑ Grand Parent ❑ Legal Guardian ❑ Other

Residence____ ❑ Own ❑ Rent
Street City State Zip

Mailing Address______________________________ Email________________
Street City State Zip

How long at this address____________ Previous Address______________________________
(If less than 3 yrs) Street City State Zip

Home Phone________________ Work Phone________________ Cell Phone________________

Social Security #________________ Birthdate________________

Employer____________________ Occupation______________ Length Employed ______________

Spouse's Name______________________________ Relationship to Patient____________
Last First Middle

Employer____________________ Occupation______________ No. Years Employed____________

Social Security #________________ Birthdate________________ Cell Phone________________

Emergency Information

Name of nearest relative not living with you________________________________

Complete Address____

Phone________________________ Relationship:________________________

Insurance Information

Policy Holder's Name______________________________ Insurance Co.________________

Subscriber ID________________ Subscriber D.O.B.__________ Group No.________________

Insurance Co. Address______________________________ Insurance Co. Phone____________

Policy Holder's Employer____

Do you have dual coverage? No ❑ Yes ❑ If yes:

Policy Holder's Name ____

Insurance Company________________________ Group No.________________________

Insurance Co. Address______________________________ Insurance Co. Phone____________

Policy Holder's Employer____

I understand that where appropriate, credit bureau reports will be obtained.

Signature of patient or parent if minor ____

Updates (date & initial)____

CONFIDENTIAL (for record and pretreatment evaluation)

DENTAL HEALTH HISTORY

GENERAL DENTIST ____________________

DATE OF LAST DENTAL CLEANING ____________________ DATE OF LAST DENTAL X-RAYS ____________________

WHAT IS THE TOP PRIORITY WHILE BEING TREATED? ❑ COSMETIC ❑ FUNCTION ❑ COMFORT ❑ LONGEVITY

DO YOU HAVE ANY CONCERNS REGARDING TREATMENT? ____________________

CHECK IF YOU HAVE HAD PROBLEMS WITH ANY OF THE FOLLOWING:

❑ BAD BREATH
❑ BLEEDING GUMS
❑ CLICKING OR POPPING JAW
❑ FOOD COLLECTION BETWEEN THE TEETH
❑ MOUTH BREATHING
❑ GRINDING OR CLENCHING TEETH
❑ LOOSE TEETH OR BROKEN FILLINGS
❑ GUM DISEASE
❑ SORES OR GROWTHS IN YOUR MOUTH
❑ NONE
❑ SENSITIVITY TO HOT
❑ SENSITIVITY TO SWEETS
❑ SENSITIVITY WHEN BITING
❑ SENSITIVITY TO COLD

HOW OFTEN DO YOU BRUSH? ____________________ HOW OFTEN DO YOU FLOSS? ____________________

HOW YOU BEEN GIVEN ORAL HYGIENE INSTRUCTIONS ON: ❑ Brushing ❑ FLOSSING

DO YOU USE TOBACCO PRODUCTS? ❑ YES ❑ NO IF YES, HOW LONG? ______

MEDICAL HISTORY

PHYSICIAN'S NAME ____________________ DATE OF LAST VISIT ____________________

HAD YOU HAD ANY SERIOUS ILLNESSES OR OPERATIONS? ____________ IF YES, DESCRIBE ____________________

____

WOMEN: ARE YOU PREGNANT? ________ NURSING? TAKING BIRTH CONTROL PILLS? ____________________

CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

❑ AIDS OR HIV INFECTION
❑ ALLERGIES
❑ ANEMIA
❑ ARTHRITIS, RHEUMATISM
❑ ARTIFICIAL HEART VALVES
❑ ARTIFICIAL JOINTS
❑ ASTHMA
❑ BACK PROBLEMS
❑ BLOOD DISEASE
❑ BULIMIA
❑ MITRAL VALVE PROLAPSE
❑ CANCER
❑ CEREBRAL PALSY
❑ CHEMICAL DEPENDENCY
❑ CHEMOTHERAPY
❑ CIRCULATORY PROBLEMS
❑ DIABETES
❑ DOWNS SYNDROME
❑ EPILEPSY
❑ FAINTING
❑ GLAUCOMA
❑ VENEREAL DISEASE
❑ HEADACES
❑ HEMOPHILIA
❑ HEART MURMUR
❑ HEART PROBLEMS
DESCRIBE ____________
____
____
❑ HEPATITIS A OR B
❑ HIGH BLOOD PRESSURE
❑ JAW PAIN
❑ KIDNEY DISEASE
❑ LIVER DISEASE
❑ NERVOUS PROBLEMS
❑ PACEMAKER
❑ PSYCHIATRIC CARE
❑ RADIATION TREATMENT
❑ RESPIRATORY DISEASE
❑ RHEUMATIC FEVER
❑ SHORTNESS OF BREATH
❑ SINUS TROUBLE
❑ THYROID PROBLEMS
❑ TONSILLITIS
❑ TUBERCULOSIS
❑ ULCER
❑ NONE

MEDICATIONS

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? ❑ Y ❑ N

IF YES, PLEASE LIST: ____________________

____

PHARMACY NAME ____________________

PHONE ____________________

ALLERGIES

❑ ASPIRIN
❑ BARBITURATES
❑ CODEINE
❑ LOCAL ANESTHETIC (NOVOCAINE)
❑ PENICILLIN
❑ SULFA
❑ OTHER: ____________
❑ LATEX
❑ NONE

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 my 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 payers 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 service rendered on my behalf or my dependents.

____________________ ____________________

Signature of patient or parent if minor Date