Thank You for Selecting Our Dental Team

To help us meet all of 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.

Patient Information *(confidential)*

Name _____ Date _____

SSN # _____ Birthdate _____

Home Phone _____ Cell Phone _____

Address _____

City_____ State _____ Zip _____

Email _____

Circle Appropriate Choice: Minor • Single • Married • Separated • Divorced • Widowed

If Student, Name of College _____ City _____ State_____

Spouse/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 _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS # _____

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

Cash • Personal Check • MasterCard • Visa • Discover • Care Credit

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Date Employed _____

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

Employer Address _____ City _____ State _____ Zip _____

Insurance Company_____ Group # _____

Address _____ Policy/ID # _____

Do you have additional Insurance Yes • No (If Yes, Please Complete the Following)

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Date Employed _____

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

Employer Address _____ City _____ State _____ Zip _____

Insurance Company_____ Group # _____

Address _____ Policy/ID # _____

Patient Medical History

Family Physician _____ Office Phone _____ Date of Last Exam _____

1.	Are you under medical treatment now?	Yes	No	10.	Are you wearing Contact Lens?	Yes	No
2.	Have you ever been hospitalized for any surgical operations or serious illness within the last 5 years? If yes, please explain _____ _____	Yes	No	11.	Are you Allergic to or have you had any reactions to the following?		
					Local Anesthetics (e.g. Novocain)	Yes	No
					Penicillin or any other Antibiotics	Yes	No
					Sulfa Drugs	Yes	No
					Barbiturates	Yes	No
3.	Are you taking any medication(s) including non-prescription medicine? List Names: _____ _____	Yes	No		Sedatives	Yes	No
					Iodine	Yes	No
					Aspirin	Yes	No
					Any Metals (e.g. Nickel, Mercury, etc.)	Yes	No
					Latex Rubber	Yes	No
4.	Have you ever taken Fen-Phen/Redux?	Yes	No		Other_____	Yes	No
5.	Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes	No	12.	Do you have a persistent cough or throat? clearing not associated with a known illness (lasting more than 3 weeks)?	Yes	No
6.	Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	Yes	No	13.	Woman Only: Are you pregnant or think you may be pregnant?	Yes	No
7.	Do you use tobacco?	Yes	No		Are you nursing?	Yes	No
8.	Do you use controlled substances?	Yes	No		Are you taking Oral Contraceptives?	Yes	No
9.	Do you need to be pre-medicated with antibiotics prior to dental appointments?	Yes	No	14.	Do you have or have you ever had any of the following?		

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problem	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
						Yellow Jaundice	Yes No

Have you ever had any serious illness not listed above? Yes No

Patient Dental History

Name of previous Dentist _____ Date of Last Exam _____

Previous Dentist Location _____ Date of Last Cleaning _____

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

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 and 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)

X_____ Doctor's Signature