



PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

1		
DATE		
LAST NAME	FIRST	M.I.
PREFERS TO BE CALLED BY		
ADDRESS		
ADDRESS 2		
CITY	STATE	ZIP
HOME PHONE NO.		
CELL	WORK PHONE	
EMAIL		
PREFERRED METHOD OF CONTACT: <input type="checkbox"/> HOME PHONE <input type="checkbox"/> CELL <input type="checkbox"/> WORK PHONE <input type="checkbox"/> EMAIL <input type="checkbox"/> TEXT		
BIRTHDATE	AGE	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
FAMILY STATUS: <input type="checkbox"/> CHILD <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		
SCHOOL (IF APPLICABLE)		GRADE
CITY	STATE	
SOCIAL SECURITY NO.		

2	
DENTAL INSURANCE	
PRIMARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	PATIENT'S RELATIONSHIP TO INSURED: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	
SECONDARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	PATIENT'S RELATIONSHIP TO INSURED: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	

4	
ACCOUNT INFORMATION	
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT	
NAME	
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.
ADDRESS	
CITY	STATE ZIP
PHONE NO.	
YOU	
NAME	
OCCUPATION	
EMPLOYER'S NAME	
ADDRESS	CITY
PHONE NO.	
YOUR SPOUSE	
NAME	
OCCUPATION	
EMPLOYER'S NAME	
ADDRESS	CITY
PHONE NO.	

3	
GETTING TO KNOW YOU	
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?	
NAME	RELATIONSHIP
YOU WERE REFERRED TO US BY	
PERSON TO CONTACT FOR EMERGENCY	
RELATIONSHIP	
PHONE NUMBER	
ADDRESS	
CITY	STATE ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU	
RELATIONSHIP	
PHONE NUMBER	
ADDRESS	
CITY	STATE ZIP

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary, I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Parent/Guardian Name: _____
(if patient is a minor)

Witness Name: _____

DENTAL HISTORY

PATIENT NAME (Last, First)		
DATE OF BIRTH	PATIENT ACCOUNT NO. (OFFICE ONLY)	MEDICAL ALERT (OFFICE ONLY)

Welcome! So that we may provide you with the best possible care, please complete this form and the medical history form. All information is completely confidential.

What is the reason for your visit today?

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit?

Previous Dentist's Name _____ Telephone _____

Address _____ City _____ State _____ Zip _____

How often do you have dental cleanings and examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Sonicare, waterpik, interdental brushes, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to: **Y** **N**

- Hot or cold?
- Sweets?
- Biting or Chewing?
- Have you noticed any mouth odors or bad tastes?
- Do you frequently get cold sores, blisters, or any other oral lesions?

Do your gums bleed when you brush or floss?

- Do you have dry mouth?
- Have you noticed any loose teeth or change in your bite?
- Does food tend to become caught in between your teeth?

If yes, where? _____

Do you: **Y** **N**

- Clench or grind your teeth while awake or asleep?
- Bite your lips or cheeks regularly?
- Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)
- Mouth breathe while awake or asleep?
- Have tired jaws, especially in the morning?
- Snore or have any other sleeping disorders?
- Smoke/chew tobacco or use other tobacco products?

Have you ever had: **Y** **N**

- Orthodontic treatment?
- Oral surgery?
- Periodontal treatment?
- Your teeth ground or the bite adjusted?
- A bite plate or mouth guard?
- A serious injury to the mouth or head?

If so, please describe, including cause: _____

Have you experienced: **Y** **N**

- Clicking or popping of the jaw?
- Pain? (joint, ear, side of face)
- Difficulty in opening or closing the mouth?
- Difficulty in chewing on either side of the mouth?
- Headaches, neckaches or shoulder aches?
- Sore muscles (neck or shoulders)?

Are you satisfied with your teeth's appearance?

If not, what would you like to change? _____

Do you feel nervous about having dental treatment?

If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience?

If yes, please describe: _____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe: _____

MEDICAL HISTORY

PATIENT NAME (Last, First)		
DATE OF BIRTH	PATIENT ACCOUNT NO. (OFFICE ONLY)	MEDICAL ALERT (OFFICE ONLY)

- Y N**
1. Have you been under the care of a medical doctor during the past two years?
 If yes, for what? _____
 Physician's Name _____ Telephone _____
 Address _____ City _____ State ____ Zip _____
2. Would you consider yourself to be in fairly good health?
3. Are you taking any medication or drugs currently, including regular doses of aspirin or over-the-counter herbal medicines?
 If yes, please list name of medication:

MED 1	MED 2	MED 3	MED 4
MED 5	MED 6	MED 7	MED 8

- Y N**
4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or similar drugs?
5. Are you aware of having an allergic (**or adverse**) reaction to any medication or substance?
 If yes, please list: _____
6. Have you been a patient in the hospital during the past five years?
7. Indicate which of the following you have had, or have at present. Check **Y** (Yes) or **N** (No) for each item.

	Y	N		Y	N		Y	N
Heart (Surgery, Disease, Attack)	<input type="radio"/>	<input type="radio"/>	Ulcers	<input type="radio"/>	<input type="radio"/>	Hepatitis __A __B __C	<input type="radio"/>	<input type="radio"/>
Chest Pain	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>	Venereal Disease	<input type="radio"/>	<input type="radio"/>
Congenital Heart Disease	<input type="radio"/>	<input type="radio"/>	Thyroid Problems	<input type="radio"/>	<input type="radio"/>	A.I.D.S./H.I.V. Positive	<input type="radio"/>	<input type="radio"/>
Heart Murmur	<input type="radio"/>	<input type="radio"/>	Glaucoma	<input type="radio"/>	<input type="radio"/>	Cold Sores/Fever Blisters	<input type="radio"/>	<input type="radio"/>
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	Contact Lenses	<input type="radio"/>	<input type="radio"/>	Blood Transfusion	<input type="radio"/>	<input type="radio"/>
Mitral Valve Prolapse	<input type="radio"/>	<input type="radio"/>	Emphysema	<input type="radio"/>	<input type="radio"/>	Hemophilia	<input type="radio"/>	<input type="radio"/>
Artificial Heart Valve	<input type="radio"/>	<input type="radio"/>	Chronic Cough	<input type="radio"/>	<input type="radio"/>	Sickle Cell Disease	<input type="radio"/>	<input type="radio"/>
Heart Pacemaker	<input type="radio"/>	<input type="radio"/>	Tuberculosis	<input type="radio"/>	<input type="radio"/>	Bruise Easily	<input type="radio"/>	<input type="radio"/>
Rheumatic Fever	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>	Liver Disease	<input type="radio"/>	<input type="radio"/>
Arthritis/Rheumatism	<input type="radio"/>	<input type="radio"/>	Hay Fever	<input type="radio"/>	<input type="radio"/>	Yellow Jaundice	<input type="radio"/>	<input type="radio"/>
Cortisone Medicine	<input type="radio"/>	<input type="radio"/>	Latex Sensitivity	<input type="radio"/>	<input type="radio"/>	Neurological Disorders	<input type="radio"/>	<input type="radio"/>
Swollen Ankles	<input type="radio"/>	<input type="radio"/>	Allergies or Hives	<input type="radio"/>	<input type="radio"/>	Epilepsy or Seizures	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>	Sinus Trouble	<input type="radio"/>	<input type="radio"/>	Fainting or Dizzy Spells	<input type="radio"/>	<input type="radio"/>
Diet (Special Restricted)	<input type="radio"/>	<input type="radio"/>	Radiation Therapy	<input type="radio"/>	<input type="radio"/>	Nervous/Anxious	<input type="radio"/>	<input type="radio"/>
Artificial Joints (hip, knee, etc.)	<input type="radio"/>	<input type="radio"/>	Chemotherapy	<input type="radio"/>	<input type="radio"/>	Psychiatric/Psychological Care	<input type="radio"/>	<input type="radio"/>
Kidney Trouble	<input type="radio"/>	<input type="radio"/>	Tumors	<input type="radio"/>	<input type="radio"/>	Cancer	<input type="radio"/>	<input type="radio"/>

- Y N**
8. Do you use more than two pillows to sleep?
9. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?
10. Do you have or have you had any disease, condition, or problem not listed?
 If yes, please list: _____
11. **Women:** Are you pregnant or think you may be pregnant? Yes ___Months No
 Nursing? Yes No Do you use birth control medications? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

PATIENT/GUARDIAN SIGNATURE	DATE:	DOCTOR SIGNATURE	DATE: