

Welcome! Please complete this form. This Information must be accurate or we cannot file a claim for you.
Thank you for your attention to detail. If you have any questions or need assistance, please ask us. We are happy to help!

Patient Information

Name _____ Date of Birth _____ Email _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell _____

SSN# _____

Check Appropriate Box(es): Minor Student Single Married Divorced Widowed Separated

If the Patient is a minor, who is responsible for them? _____

If Student, Name of School/College _____ Full-time Part-time

Person To Contact in Case of Emergency _____ Phone # _____

Whom May We Thank for Referring You? _____

Insurance/ Employer Information

Name of Person responsible for this account _____

Relationship to patient _____

Name of Employer _____ What is your profession? _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Claims phone # _____

Do You Have Any Additional Dental Insurance? Yes No

Dental History

Name of Previous Dentist and location _____ Date of last exam _____

1. Do you like your smile? Yes No If No, what would you like to change? _____

2. Have all your past dental experiences been good? Yes No _____

3. Is there anything in particular that you would like us ALWAYS to do? Yes No _____

4. Is there anything in particular that you would like us NEVER to do? Yes No _____

5. Do you have frequent headaches? Yes No

6. Do you clench or grind your teeth? Yes No

7. Do your gums bleed while brushing? Yes No

8. Do you feel pain in any of your teeth? Yes No

9. Are your teeth sensitive to hot or cold? Yes No

10. Do you have any lumps or sores in or near your mouth? Yes No

11. Do you jaws click, grind, or hurt? Yes No

Health History

- | | | | |
|--|-----|----|------------------------------------|
| 1. Are you under medical treatment? | Yes | No | For what? _____ |
| 2. Are you allergic to any medications? | Yes | No | If yes, which? _____ |
| 3. Have you ever had an allergic reaction to anything else? (Latex? Nickel?) | Yes | No | What? _____ |
| 4. Are you taking any drugs or medications? | Yes | No | If yes, please list _____
_____ |
| 5. Do you have any heart conditions or problems? | Yes | No | If yes, what? _____ |
| 6. Have you had a joint replacement? | Yes | No | If yes, when? _____ |
| 7. Do you use Tobacco? | Yes | No | If yes, what type? _____ |
| 8. Do drink alcohol? | Yes | No | How many drinks/week? _____ |
| 9. Have you ever been told to take antibiotics before a dental visit? | Yes | No | |
- 10. For women only**
- | | | |
|-------------------------------------|-----|----|
| Are you pregnant? | Yes | No |
| Are you nursing? | Yes | No |
| Are you taking oral contraceptives? | Yes | No |
11. Do you have, or have you had any of the following?
- | | | | | | |
|-----------------------|-----|----|------------------------------|-----|----|
| High Blood pressure | Yes | No | Heart Disease | Yes | No |
| Heart Attack | Yes | No | Pacemaker | Yes | No |
| Rheumatic Fever | Yes | No | Heart Murmur | Yes | No |
| Swollen Ankles | Yes | No | Angina | Yes | No |
| Fainting/Seizures | Yes | No | Frequently Tired | Yes | No |
| Asthma | Yes | No | Anemia | Yes | No |
| Low Blood Pressure | Yes | No | Emphysema | Yes | No |
| Epilepsy | Yes | No | Cancer | Yes | No |
| Leukemia | Yes | No | Arthritis | Yes | No |
| Diabetes | Yes | No | Hepatitis | Yes | No |
| Kidney Disease | Yes | No | Sexually Transmitted Disease | Yes | No |
| AIDS or HIV infection | Yes | No | Stomach Troubles/Ulcers | Yes | No |
| Thyroid Problem | Yes | No | Chest Pains | Yes | No |
| Easily Winded | Yes | No | Stroke | Yes | No |
| Hay Fever/ Allergies | Yes | No | Tuberculosis | Yes | No |
| Radiation Therapy | Yes | No | Glaucoma | Yes | No |
| Liver Disease | Yes | No | Mitral-Valve Prolapse | Yes | No |
| Respiratory Problems | Yes | No | Other _____ | | |
12. Do you have any other **diseases, medical problems, or psychological problems** not listed on this form? If so, please explain. _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health or medication in order to avoid SERIOUS OR POSSIBLY FATAL CONSEQUENCES.

PATIENT SIGNATURE _____ Date _____

DOCTOR'S SIGNATURE _____ Date _____