WELCOME TO OUR OFFICE

Name____ Birthdate____________________________

Nickname________________________ Social Security Number_____________________________

☐Male ☐Female ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Address____
City, State and Zip Code____Home Phone______________
E-Mail Address ____ Work Phone________________
Employer_________________________Occupation___________________Cell Phone________________
Employment Address____
Who May We Thank for Referring You? ____
Someone not living with you to notify in case of emergency________________________Phone_____________

Responsible Party (if other than self)

Name____Birthdate___________________________
Relationship to Patient__________________________Social Security #_____________________________
Address____
City, State and Zip Code____Home Phone______________
Employer____________________________Occupation_________________Work Phone______________

Dental Insurance Information

Primary Insurance

Name of Insured_________________________
Relationship to Patient____________________
Insured's Birthdate_______________________
Soc. Sec. #____________________________
Insurance Company______________________
Membership #__________________________
Group #_______________________________
Effective date __________________________

Additional Insurance

Name of Insured________________________________
Relationship to Patient___________________________
Insured's Birthdate_______________________________
Soc. Sec. #_____________________________________
Insurance Company_______________________________
Membership #____________________________________
Group #____
Effective Date____________________________________

Authorization and Release

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I authorize the release of any information concerning patient's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
I authorize the release of any information concerning patient's health care, advice and treatment to another dentist.
I authorize and request the insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.
I authorize the dentist or staff to take photographs of my care and treatment, which may be used for the advancement of dentistry and educational viewing by other dentists and staff.
I understand that the dental insurance carrier may pay less than the actual fees for service. I agree to be responsible for all services rendered on the patient's behalf.
I attest to the accuracy of the information on this page.

____
Signature of Patient or Parent/Legal Guardian Relationship to Patient Date

Name:________________________ Cell/Home phone:__________________ email:_____________________________

Address: ____

Physician:_______________________________ Office Phone: _____________________ Date of Last Exam:__________________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s) including non-prescription medication ?	☐	☐
Please list:______________________________________		
4. Do you use tobacco?	☐	☐
5. Do you use cocaine or other drugs?	☐	☐
6. Women Only:		
a) Are you pregnant or think you may be pregnant? Due date: _______________	☐	☐
b) Are you nursing?	☐	☐
c) Are you using birth control pills	☐	☐

7. Are you allergic to or have you had any reactions to the following?

	Yes	No
Local Anesthetic	☐	☐
Penicillin or other antibiotic	☐	☐
Sulfa Drugs	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Tylenol	☐	☐
Aspirin	☐	☐
Codeine or other narcotics	☐	☐
Latex	☐	☐
Others	☐	☐

____

8. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Thyroid Problem	☐	☐	Sexually transmitted Disease	☐	☐
Heart Attack	☐	☐	Heart Disease	☐	☐	Ulcers	☐	☐
Rheumatic Fever	☐	☐	Cardiac Pacemaker	☐	☐	Chest Pains	☐	☐
Swollen Ankles	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Fainting/Seizures	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Asthma	☐	☐	Mitral Valve Prolapse	☐	☐	Tuberculosis	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Radiation Therapy	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Glaucoma	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Recent Weight Loss	☐	☐
Kidney Disease	☐	☐						
AIDS or HIV	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐

Any other medical conditions:

Patient Dental History

Date of Last Exam: _____________

Date of Last X-ray: ________________

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold?	☐	☐
3. Are your teeth sensitive to sweet or sour foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you had ever experienced any of the following problems to your jaw?		
a) Clicking	☐	☐
b) Pain (joint, ear, side of face)	☐	☐
c) Difficulty in opening and closing	☐	☐
d) Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you had orthodontic work?	☐	☐
13. Have you ever had any prolonged bleeding following extractions?	☐	☐
14. Are you happy with the appearance of your smile?	☐	☐
15. Would you like to have a complimentary imaging of your smile?	☐	☐

Signature of patient or parent if minor: ____ **Date**: __________________________

Medical History Update:

Date	Comments	Patient's Signature	Initials