WELCOME!

Thank you for choosing our office. We strive to provide you with the most gentle, quality care possible.
If you have any questions, or we can help you in any way, please feel free to ask.

Patient Information (Confidential):

Name _____ (If child, parent/guardian name) _____
Last name *First name* *Initial*

Birthdate_____Sex_____Age_____ Soc. Sec. #_____
Home Address_____City _____State_____Zip_____
Home Phone_____ Work Phone_____ Cell phone_____
E-Mail_____ Drivers License #_____

How did you hear about our practice? _____
Employer_____Occupation_____How long there? _____May we call?_____
Employer Address_____City _____State_____Zip_____

Spouse's Name (Or other parent/guardian)_____Soc. Sec. #_____
Spouse's Employer_____Occupation_____How long there? _____May we call?_____
Spouse's Employer Address_____City _____State_____Zip_____

If patient is a student: Name of school/college: _____City & State_____Full time or part time?_____

Primary Insurance:

Name of Insured _____
Birthdate_____Relationship to patient_____
Address (if different from patient)_____
Dental Insurance Co._____Phone_____
Social Security #_____ Subscriber ID #_____
Group, Contract or Local or union #_____

Additional Insurance:

Name of Insured _____
Birthdate_____Relationship to patient_____
Address (if different from patient)_____
Dental Insurance Co._____Phone_____
Social Security #_____ Subscriber ID #_____
Group, Contract or Local or union #_____

Copayments:

To accept insurance, we now debit copayments automatically to your credit card or bank account. If you would like us to accept your insurance, please provide credit card information or voided check:

CIRCLE ONE: Visa MasterCard Discover Amex
Account#_____Expiration date_____Name on card_____
☐ Credit Card ☐ Debit Card ☐ ATM ☐ Voided check attached.

In Case of Emergency:

Name and City of primary care physician _____
Someone we may contact, not living with you: _____Phone #'s (home, work, cell)_____

Authorization:

I authorize my insurance company to make payments directly to the dental office for benefits otherwise payable to me. I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities as deemed necessary by this office. I authorize use of this signature for all insurance submissions.

I understand that I am responsible for all charges whether or not they are covered by insurance, as well as any additional collection costs if this office determines they are necessary. I authorize this office to charge my credit card or bank account for any unpaid balances, including those after insurance payment. I further authorize this office to charge my credit card to cover any unpaid fees not paid by insurance within 60 days. I understand that in certain circumstances, my credit report may be requested. I have reviewed the information on this form, and it is accurate to the best of my knowledge. I understand that check payments may be converted to automatic bank drafts.

I have received a copy of this office's Notice of Privacy Practices.

Signature _____Date_____
Patient or Responsible Party

Dental History

Patient Name_____ Age _____ Date _____

Reason for seeking care today: ___ Exam ___ Cleaning ___ Specific Problem _____ (Please describe)

Please check all that apply:

- ☐ Toothache
- ☐ Broken filling or tooth
- Sensitivity to:
  - ☐ Cold
  - ☐ Hot
  - ☐ Sweets
  - ☐ Chewing
- ☐ Food catches
- ☐ Loose teeth
- ☐ Floss breaks easily or hurts
- ☐ Bite or teeth have shifted
- ☐ Often bite cheeks
- ☐ Frequent dry mouth
- ☐ Concerned about breath
- ☐ Unhappy with previous dental work
- ☐ Gums bleed
- ☐ Gums tender
- ☐ Growths, sores
- ☐ Cold sores, fever blisters
- ☐ Cracked, chapped lips
- ☐ Bad taste in mouth
- ☐ Sinus problems
- ☐ Mouth breathe – Difficulty breathing through nose
- ☐ Dry or strained eyes
- ☐ Shoulder, neck or headaches
- ☐ Clench or grind teeth
- ☐ Jaw joint pain
- ☐ Clicking or popping of joint.
- ☐ Unable to open mouth wide
- ☐ Jaw gets tired easily.
- ☐ Hold things between teeth (Pipe, pencil, nails, pins)
- ☐ Bite fingernails
- ☐ Unusual habits with teeth
- ☐ Wore braces
- ☐ Previous gum treatment
- ☐ Previous bite treatment

Would you like whiter teeth? _____ Is there anything that bothers you (even just a little) about the appearance of your teeth or smile?

_____

Please rate 1-10 how anxious you are about dental treatment (1= totally relaxed) _____

Have you ever had a bad experience at the dentist? (Treatment? Staff? Billing?) _____

Why did you leave your previous dentist? _____

Did your parents have difficulties with their teeth or dental treatments? _____

Medical History

Physicians Name: _____

City: _____ Phone _____

Have you been hospitalized for any reason? Please describe:

_____

_____

Are you taking any medications or drugs (including nutritional supplements?) Please list: (Continue on back of form if needed)

_____

_____

Are you taking or have ever taken Bisphosphonates? If yes, name of drug and how long taken. _____

Are you allergic to penicillin, aspirin, local anesthetics, latex, sulfa, codeine, jewelry, metal, tetrocycline, food allergies, other? _____

_____

Do you smoke? How much/day? _____

Pregnant? Due date _____ Are you nursing? _____

Are you seeing a physician now or planning to see one for any reason? Please explain: (Continue on back of form if needed)

_____

_____

_____

_____

Please check all that apply:

- ☐ Previous injury to head or neck
- ☐ Heart problem
- ☐ HeartAttack
- ☐ Angina, chest pain
- ☐ Heart murmur
- ☐ Scarlet, Rheumatic fever
- ☐ Mitral valve prolapse
- ☐ Irregular heartbeat
- ☐ High or low blood pressure
- ☐ Pacemaker
- ☐ Artificial joint, bones, valves
- ☐ Neurological disorders
- ☐ Depression
- ☐ TB
- ☐ Diabetes
- ☐ HIV or AIDS
- ☐ Kidney problem
- ☐ Liver problem, jaundice
- ☐ Cirrhosis, Hepatitis
- ☐ Cancer, Radiation, Chemotherapy
- ☐ Respiratory problem
- ☐ Bloody, persistent cough
- ☐ Asthma, Emphysema
- ☐ Anemia
- ☐ Sickle cell disease
- ☐ Osteoporosis (list meds)

_____

- ☐ Psychotic problems
- ☐ STD
- ☐ Digestive problem, ulcer
- ☐ Thyroid disease
- ☐ Glaucoma
- ☐ Bleed or bruise easily
- ☐ Stroke
- ☐ Epilepsy or Seizures
- ☐ Parkinson's
- ☐ Alzheimer's
- ☐ Back problem
- ☐ Hives, rash
- ☐ Dry eyes
- ☐ Colitis
- ☐ Sinus Problems
- ☐ Shingles
- ☐ Shortness of breath
- ☐ Snoring, sleep apnea
- ☐ No energy
- ☐ Fainting or dizzy
- ☐ Unexplained weight loss
- ☐ Chewing tobacco
- ☐ Drug or alcohol addiction
- ☐ 2 or more social drinks/day
- ☐ Anxiety or nervous disorder
- ☐ Insomnia
- ☐ Contact lenses
- ☐ Herpes/Fever Blsiters

Any other illnesses not checked above? _____

Please indicate if you would prefer to speak privately with the dentist about a medical issue: ☐ Yes ☐ No

Please rate the following indicators of your daily stress level: 1-10 : (1 = low, 10 = high)

____Overworked, too busy, pressured ____ Feel frustrated ____ Get upset or "snap" easily ____Depression, anxiety

I will inform this office of any changes in my health status. I understand that dental treatment and local anesthesia entail risks such as bleeding, infection, nerve damage, or fracture of teeth or bone. I certify that the above information is complete and accurate to the best of my knowledge.

Patient Signature (parent or guardian) _____ Date_____

Dentist' Signature_____ Date_____