About You

Name: _____ ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr.
Last

_____ ☐ Male ☐ Female
First Middle Initial

I prefer to be called: _____

Birth Date: ____/____/____ SS# _____

Home Address: _____

_____

Home Phone: (_____)_____

Work Phone: (_____)_____Ext. _____

Cell/Pager: (_____)_____

Employer: _____

Email Address: _____@_____

If it were an option, would you prefer to receive appointment reminders by email? ..... Yes ☐ No ☐

Have we seen any other members of your family?

_____

Previous Dentist: _____

Last visit date: _____

Please let us know if there is someone we can thank for referring you.

_____

Spouse/Partner Information

Name: _____

Employer: _____

Cell Phone: (_____)_____

Work phone: (_____)_____Ext. _____

Emergency Contact Information

His/Her Name:_____

Relation: _____

Home Phone: (_____)_____

Work Phone: ( ) Ext.

Dental Insurance----*Please fill completely*

☐ **I do not have dental insurance**

Primary Dental Insurance

Insurance Co. Name: _____

Group Number _____

Subscriber's Name _____

Subscriber's Birth Date: _____/_____/_____

Subscriber's SS#:_____

ID# (if different from SS#) _____

Subscriber's Employer _____

Relationship to Patient: _____

☐ **I do not have secondary dental insurance**

Secondary Dental Insurance (if applicable)

Insurance Co. Name: _____

Group Number _____

Subscriber's Name _____

Subscriber's Birth Date: _____/_____/_____

Subscriber's SS#:_____

ID# (if different from SS#) _____

Subscriber's Employer _____

Relationship to Patient: _____

Billing Address (if other than your own)

Name: _____

Relation:_____

Address: _____

_____

Phone #: (_____)_____

Continued on back...

Medical History

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

If so, please explain: _____

_____

Do you need to take antibiotics before dental appointments? ..... ☐ Yes ☐ No

If so, please explain: _____

Are you taking prescription and/or over-the-counter drugs? ..... ☐ Yes ☐ No

Please list each one: _____

_____

_____

Be sure to list any blood thinners (i.e. Coumadin, Warfarin) and biphosphonates (i.e. Fosamax, Actonel, Boniva) for osteoporosis.

Do you smoke or use tobacco in any form? ..... ☐ Yes ☐ No

For Women:

Are you taking birth control pills? ..... ☐ Yes ☐ No

Are you pregnant? ..... ☐ Yes ☐ No

If yes, how many weeks? ..... ____ weeks

Are you nursing? ..... ☐ Yes ☐ No

Please check if you have ever had any of the following medical problems:

- ☐ Abnormal Bleeding
- ☐ Alcohol/Drug Abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Bones/Joints/ Valves
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer/Chemotherapy
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes/Fever Blisters
- ☐ High Blood Pressure
- ☐ HIV+/AIDS
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Transplant
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Venereal Disease

☐ **None of the above applies**

List any other serious medical conditions you have had:

_____

_____

Please check if you are allergic any of the following:

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Jewelry / Metals
- ☐ Latex
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Other

☐ **None of the above applies**

Please list any other drugs that you are allergic to:

_____

_____

Dental Information

Reason for today's visit_____

_____

Are you currently in pain? ..... ☐ Yes ☐ No

Have you ever had a serious or difficult problem associated with previous dental work? ..... ☐ Yes ☐ No

Have you experienced any of the following in your jaw joints?

- Clicking ..... ☐ Yes ☐ No
- Pain (joint, ear, neck) ..... ☐ Yes ☐ No
- Difficulty in opening or closing ..... ☐ Yes ☐ No
- Difficulty chewing ..... ☐ Yes ☐ No

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

Have you had any orthodontic treatment? ..... ☐ Yes ☐ No

Do you wear dentures or partials? ..... ☐ Yes ☐ No

Do your gums bleed while brushing or flossing? ... ☐ Yes ☐ No

How many times a **week** do you floss? ..... _____ times/week

How many times a **day** do you brush? _____ times/day

Type of bristles ☐ Hard ☐ Medium ☐ Soft

Are you satisfied with the appearance of your teeth? ☐ Yes ☐ No

Payment is due in full at the time of treatment unless prior arrangements have been made. Insurance co-pays are due within 30 days of the billing date. Since we set aside time specifically for you, please note that there is a $75 fee for breaking an appointment without contacting us or cancelling without providing us at least 24 business hours' notice.

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status.

I authorize my insurance company to pay the benefits otherwise payable to me.

I understand that I am responsible for payment of services rendered and also responsible for paying any portion of my treatment fees that my insurance does not cover. I also understand that any fees for overdue payments, broken appointments, and cancellation with less than 24-business-hour notice will be my responsibility.

X_____ ___/___/___

Signature of Patient Date