

WELCOME

Thank you for selecting our dental healthcare team! To help us meet all your dental healthcare needs, please fill out this form completely.

Patient Information (Confidential) Today's Date _____

Name _____ Birthdate _____ Age _____ Gender: M F
(Last Name) (First Name)

Address _____ City _____ Zip _____ SSN# _____

Email _____ Home Ph. _____ Cell Ph. _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

If Student, Name of School / College _____ Grade level _____

Patient's / Guardian's Employer _____ Work Ph: _____

Spouse of Patient/Guardian's Name _____

Person to Contact in case of emergency _____ Ph. _____

Whom may we thank for referring you? _____

I will be paying for today's service by:
 Cash Check Credit Card Medicaid I would like to discuss payment options.

Responsible Party

Name of the Person Responsible for this Account _____ Relationship to Patient _____

Address (if different from above) _____

Email _____ Home Ph. _____ Cell Ph. _____

Driver's License # _____ Birthdate _____

Employer _____ Work Ph. _____ SSN# _____

Is this person currently Patient in our office? Yes No

Dental Insurance Information

Name of the Insured _____ Relationship to Patient _____

Birthdate _____ SSN# _____ Date Employed _____

Name of the Employer _____ Work Ph. _____

Address of Employer _____

Insurance Company _____ Insurance Company Ph. _____

Group # _____ Policy # _____

Additional Dental Insurance Yes No If yes, please complete the following:

Name of the Insured _____ Relationship to Patient _____

Birthdate _____ SSN# _____ Date Employed _____

Name of the Employer _____ Work Ph. _____

Address of Employer _____

Insurance Company _____ Insurance Company Ph. _____

Group # _____ Policy # _____

Acknowledgement of Receipt of Notice of Privacy Practices

~ You may refuse to sign this acknowledgement ~

I, _____, have read a copy of this office's Notice of Privacy Practices and this acknowledgement will be kept of record for the following mentioned patient.

(signature of patient or guardian)

(Date)

Patient Name: _____

Patient Medical History

Physician Name _____
Date of Last Exam _____

Office Ph. _____

1. Are you under medical treatment now?					YES	NO
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 yrs.?					<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medication(s) including on-prescription medicine? If yes, please explain. _____					<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever taken Fen-Phen / Redux?					<input type="checkbox"/>	<input type="checkbox"/>
5. Do you use tobacco?					<input type="checkbox"/>	<input type="checkbox"/>
6. Do you use controlled substances?					<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have or had any of the following?					<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO		YES	NO		YES	NO
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/ Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/ Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/ Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Value Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles/ Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems	<input type="checkbox"/>	<input type="checkbox"/>
Other (if yes, please describe) _____	<input type="checkbox"/>	<input type="checkbox"/>						

8. Do you have any allergies or allergic reactions? _____					YES	NO
9. Do you have persistent cough not associated with a known illness?					<input type="checkbox"/>	<input type="checkbox"/>
10. Women only:						
Are you pregnant or think you may be pregnant?	YES	NO			<input type="checkbox"/>	<input type="checkbox"/>
Are you nursing?					<input type="checkbox"/>	<input type="checkbox"/>
Are you taking oral contraceptives?					<input type="checkbox"/>	<input type="checkbox"/>
11. Do you need to be premedicated before dental procedures due to medical conditions (i.e. heart murmurs)? If yes, please describe: _____					YES	NO
					<input type="checkbox"/>	<input type="checkbox"/>

Patient Dental History

General Dentist Name _____
Date of Last Exam _____

Office Ph. _____					
1. Do your gums bleed while brushing or flossing?					YES NO
2. Are your teeth sensitive to hot or cold liquids/ foods?					<input type="checkbox"/> <input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/ foods?					<input type="checkbox"/> <input type="checkbox"/>
4. Do you feel pain to any of your teeth?					<input type="checkbox"/> <input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth?					<input type="checkbox"/> <input type="checkbox"/>
6. Have you had any head, neck or jaw injuries?					<input type="checkbox"/> <input type="checkbox"/>
7. Have you ever experienced any of the following in your jaw.					
Clicking	<input type="checkbox"/>	<input type="checkbox"/>			
Pain (joint, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>			
Difficulty in opening or closing	<input type="checkbox"/>	<input type="checkbox"/>			
Difficulty in chewing	<input type="checkbox"/>	<input type="checkbox"/>			

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance to pay directly to the dentist or dental group insurance benefits otherwise payable to me. **I understand that my dental insurance carrier may pay less than the actual services rendered on my behalf or my dependents.**

Signature of patient (parent or guardian if minor) _____

Date _____

Date	Age	Note / Recommendation	Next Visit

Doctor's Signature _____

Date _____