"Quality Dentistry, Affordable Service, Compassionate Care."

WELCOME

Thank you for selecting us for your dental care. To ensure we select the best care for you, please complete this form. If you have any questions, please let us know.

Patient Information

Patient Name ______________________________ Date of Birth____/____/_____ SSN_____-_____-______
Patient Address ______________________________ City, State, Zip ________________________________
Home Phone (___)______________Work Phone (___)______________Cell (___)__________________
At which number(s) are we able to leave messages? ☐ Home ☐ Work ☐ Cell
Marital Status _____________________ Email Address ____
Employer _______________________________________ Occupation ________________________________
Spouse/Parent/Guardian Name ______________________________
How did you hear about our office? Whom may we thank for your referral? _____________________________

Authorization to Disclose

I authorize the disclosure of all medical information to the following person(s):
Name __________________________ Number (___)____________Relationship _____________________
Name __________________________ Number (___)____________Relationship _____________________
EMERGENCY CONTACT: Name ___________________________ Number (___)____________

Dental Insurance Information

Subscriber Name ________________________________ Relationship ___________________________
SS# or ID# _____________________________________ Date of birth ___________________________
Insured's Employer _____________________________ Occupation _____________________________
Employer Address ____
Insurance Company ______________________________ Group Number ________________________

Additional Dental Insurance Coverage

Subscriber Name ________________________________ Relationship ___________________________
SS# or ID# _____________________________________ Date of birth ___________________________
Insured's Employer _____________________________ Occupation _____________________________
Employer Address ____
Insurance Company ______________________________ Group Number ________________________

Authorization and Release

I certify that the above information is correct to the best of my knowledge. To the extent permitted by law, I consent to the use and disclosure of my protected health information to third party payers or health practitioners. I understand that the ESTIMATED co-pays, non- covered procedures and/or deductibles are DUE AT THE TIME OF SERVICE. I agree to be responsible for all remaining charges for dental services that are not paid by my dental benefit plan. This applies regardless of whether the estimated treatment included an expected insurance benefit, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to this office.

Patient/Guardian Signature____ Date:____/____/________
Dentist's Signature____ Date:____/____/________

Please Complete Other Side

Completed by Employee Only Initial________ Date:____/____/_______

Patient Name________________________ Date of Birth___/____/_____

Dental History

Are you aware of any dental problems at this time?

____

When was your last dental visit? _______________ What was done? ______________________________

Previous Dentist's Name _______________________ Address ______________________________

Is there a reason you left your previous dentist? ____

Are you experiencing or have you experienced any of the following?

- ☐ Hot/Cold Sensitivity
- ☐ Unpleasant Breath
- ☐ Bleeding Gums
- ☐ Tender Gums
- ☐ Food gets caught
- ☐ Clench or grind your teeth
- ☐ Frequent cavities
- ☐ Buildup of plaque/calculus/tartar
- ☐ Gum treatments or Periodontal Surgery
- ☐ Orthodontic Treatment
- ☐ Oral Surgery
- ☐ Endodontic Treatment *(root canal)*

How often do you brush? _____________ Manual or Electric (circle one) How often do you floss? ____________

Have you ever been told to take antibiotics prior to dental appointments? Y / N Reason? __________________

Do you usually have dental anesthetic (teeth numbed) for dental work? Y / N

Have you had any problems or complications with previous dental treatment? Y / N

Have you ever whitened your teeth? Y / N

Are you planning to keep your remaining teeth your whole lifetime? Y / N

If you could change anything about your teeth or smile, what would that be? ____________________________

Allergies

☐ Aspirin	☐ Codeine	☐ Erythromycin	☐ Hay Fever
☐ Latex	☐ Penicillin	☐ Sulfa	☐ Other_________________

Medical History

Physician's Name & Phone Number ____

Date of last physical____/____/______ Currently under a phycian's care? Y / N If yes, why__________________

Do you have or have you had any of the following conditions:

☐ Anemia	☐ Arthritis	☐ Artificial Joints	☐ Asthma
☐ Blood Disease	☐ Cancer	☐ Diabetes	☐ Dizzy Spells or Fainting
☐ Epilepsy or Seizures	☐ Excessive Bleeding	☐ Glaucoma	☐ Head Injury
☐ Heart Condition	☐ Heart Disease	☐ Heart Murmur	☐ Heart Pacemaker
☐ Hemophilia	☐ Hepatitis A (Infectious)	☐ Hepatitis B (Serum)	☐ Hepatitis C or Other
☐ Herpes	☐ High Blood Pressure	☐ HIV + / AIDS	☐ Jaundice
☐ Kidney Disease/Trouble	☐ Liver Disease	☐ Low Blood Pressure	☐ Mental Disorder
☐ Nervous Disorder	☐ Osteoporosis	☐ Pregnant or Nursing	☐ Radiation Therapy
☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism	☐ Sexually Trans. Disease
☐ Sinus Trouble	☐ Stomach Problems	☐ Stroke	☐ Tuberculosis (TB)
☐ Tumors	☐ Ulcers	☐ Other_______________	

Have you ever had a disease, condition, serious illness or major surgery not listed above? Yes/ No

If yes, explain: ____

Have you ever taken Fosamax, Boniva, Actonel or other bisphosphonates? Y / N If yes, what: _____________

Have you used tobacco products in the last 7 years? Y / N If yes, what__________________________________

Do you consume alcoholic beverages or use recreational drugs? Y / N If yes, what: ______________________

If female, are you pregnant? Y / N If yes, # of weeks ________ Nursing? Y / N

Using Birth Control Medications? Y / N

Please list all medications you are currently taking, *include prescription and non-prescription:*

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

I certify that the above information is complete and accurate.

Patient/Guardian Signature____ Date:____/____/______

Dentist's Signature____ Date:____/____/______