# Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill out this form completely.
If you have any questions or need assistance, please ask us.

**PATIENT INFORMATION** – (Confidential) Today's Date _______________

Patient's Name ________________________________________ Birthdate ________________________

Mailing Address ________________________________________________________________________

City _____________________________ State _______ Zip Code _____________

Home Phone ___________________ Work Phone _________________ Cell Phone ________________

Social Security Number _______________________ Drivers License Number ____________________

E-mail Address (for appointment reminders): _____________________________________________________

Please Circle: Minor Single Married Divorced Widow **Referred by:________________**

Spouse's Name or
Parent's Name if a Minor _______________________________ Home Phone ____________________

Spouse's or Parent's Mailing Address ______________________________________________________
City _____________________________ State _______ Zip Code ______________

Patient's Employer or
Parent's Employer _________________________________________ Work Phone __________________

Business Address _________________________________________________________________________

City _____________________________ State _______ Zip Code ______________

**Responsible Party**

Name of Person Responsible for this account _______________________________________________

Relationship to the patient ______________________________

Mailing Address ________________________________________________________________________

City _____________________________ State _______ Zip Code _____________

Employer ______________________________________________ Work Phone ____________________

Social Security Number _______________________ Drivers License Number ____________________

Do you have dental insurance? _____________

For future appointment reminders, how would you like to be contacted?

- ☐ Voice Call
- ☐ E-mail
- ☐ Text Message

## PATIENT DENTAL HISTORY

What is the reason for you making this appointment? ____________________________________________________________

**Please answer the following questions by <u>circling</u> either yes or no:**

Yes No Do your gums bleed while brushing or flossing?
Yes No Are your teeth sensitive to hot or cold liquids/foods?
Yes No Are your teeth sensitive to sweet or sour liquids/foods?
Yes No Do you feel pain in any of your teeth?
Yes No Do you have any sores or lumps in or near your mouth?
Yes No Have you had any head, neck, or jaw injuries?
Yes No Do you clench or grind your teeth during the day or at night?
Yes No Have you ever had any difficult with extractions in the past?
Yes No Have you ever had any prolonged bleeding following extractions?
Yes No Do you wear dentures or partial dentures?
If yes, date of placement ___________________________
Yes No Have you ever received oral hygiene instructions regarding the care of your teeth or gums?
Yes No Do you like your smile?

Date of last dental visit ____________________ Name & Location of last dentist ______________________________________

## PATIENT MEDICAL HISTORY

Physician's Name ___________________________________________________ Date of last medical exam __________________
Physician's Address ____________________________________________________________________________________
Physician's Phone Number _______________________
Have you been hospitalized for any surgical operation or serious illness within the last five years? _______________________
Are you under medical treatment now? _______ If yes, what for? ____________________________________________________
Please list all medications you are currently taking _____________________________________________________________
__________________________________________________________________________________________________

**Are you allergic to or have you had any reactions to the following? Please check all that apply to you:**

Penicillin or other antibiotics ______ Sulfa Drugs ______
Aspirin or ibuprofen ______ Sedatives ______
Any metals (e.g. nickel, mercury, etc.) ______ Latex rubber ______
Other allergies or reactions (please list) ____________________________________________________________________________

**Please check all medical conditions that apply to you:**

Heart Disease ____ Chest Pains ____ High Blood Pressure ____
Heart Attack ____ Cardiac Pacemaker ____ Arthritis ____
Rheumatic Fever ____ Heart Murmur ____ Stroke ____
Fainting/Seizures ____ Angina ____ Aids/HIV Infection ____
Hepatitis ____ Asthma ____ Anemia ____
Radiation Therapy ____ Low Blood Pressure ____ Emphysema ____
Glaucoma ____ Cancer ____ Epilepsy ____
Liver Disease ____ Kidney Disease ____ Joint Replacement ____
Diabetes ____ Mitral Valve Prolapse ____ Respiratory Problems ____
Osteoporosis/Bisphosphonate Use ____

Do you use tobacco? ________ Do you use alcohol? _______

**Women Only:**

Are you pregnant or think you may be pregnant? ___________ Are you nursing? ___________
Are you taking oral contraceptives? __________

## Authorization & 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 company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

__________________________________________________________________________________________________
Signature of Patient (or parent if minor) Date