DENTAL HISTORY

Reason for visit? ______________________ Are you in dental discomfort today? __________

Former Dentist: ______________ Address: ______________________ Phone: ______________

Date of last dental care: ______________________ Date of last x-rays: ______________________

Check (✓) if i you have had any problems with any of the following:

- ❑ Bad Breath
- ❑ Bleeding Gums
- ❑ Clicking or popping Jaw
- ❑ Food collection between teeth
- ❑ Grinding or clenching teeth
- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to hot
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in mouth

How often do you brush? ______________________ Floss? ______________________

How do you feel about the appearance of your teeth? ______________________

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Other information about your dental health or previous treatment: ______________________

MEDICAL HISTORY

Physician's Name: ______________________ Phone: ______________

Date of last visit: ______________ Have you had any serious illnesses or operations? ❑ Y ❑ N

If yes, describe: ______________________

Are you currently under physician care? ❑ Y ❑ N If yes, please describe: ______________________

Have you ever had a blood transfusion? ❑ Y ❑ N If yes, give approximate dates: ______________________

Women: Are you pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking birth control? ❑ Y ❑ N

Check(✓) if you have had any of the following:

- ❑ AIDS / HIV Positive
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial heart valves
- ❑ Artificial joints
- ❑ Asthma
- ❑ Atopic (allergy prone)
- ❑ Back Problems
- ❑ Blood disease
- ❑ Cancer
- ❑ Chemical dependancy
- ❑ Chemotherapy
- ❑ Circulatory problems
- ❑ Cortisone treatments
- ❑ Cough, persistent
- ❑ Cough up blood
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Food Allergies
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart murmur
- ❑ Heart problems Describe
- ❑ Hemophilia / Abnormal bleeding
- ❑ Herpes
- ❑ Hepatitis
- ❑ High blood pressure
- ❑ Jaw pain
- ❑ kidney disease or malfunction
- ❑ Liver disease
- ❑ Material allergies (**latex**, wool, metal, chemicals)
- ❑ Mitral valve prolapse
- ❑ Nervous Problems
- ❑ Pacemaker/heart surgery
- ❑ Psychiatric care
- ❑ Rapid weight gain or loss
- ❑ Radiation treatment
- ❑ Respiratory disease
- ❑ Rheumatic/Scarlet fever
- ❑ Shingles
- ❑ Shortness of breath
- ❑ Skin rash
- ❑ Spina Bifida
- ❑ Stroke
- ❑ Surgical implant
- ❑ Swelling of feet or ankles
- ❑ Thyroid disease or malfunction
- ❑ Tobacco habit
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer/Colitis
- ❑ Venereal disease

List medications you are currently taking, if any:

List drug allergies, if any:

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentists.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payments of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that I shall have to pay any fees needed to collect debts which are not paid.

Signature: ______________________________ Date: ______________

Payment is due in full at time of treatment.

WELCOME

DATE: ____________

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name: ______________________________ Nick Name: ____________

Last Name First Name Middle Initial

Social Security #: ____________ Home: ____________ Cell: ____________ Work: ____________

Address: ______________________________

City: ____________ State: ______ Zip: ____________

E-Mail: ______________________________

Sex: ❑ M ❑ F Age: ______ Birthday: ____________ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by: ____________ Occupation: ____________

Business Address: ______________________________

Student? YES / NO School: ____________ Grade: ______

Person Responsible for account: Last Name: ____________ First Name: ____________ Middle Initial: ______

Relation to patient: ____________ Birthrate: ____________ Social Sec#: ____________

Address (If different from patient): ______________________________

City: ____________ State: ______ Zip: ____________

PRIMARY INSURANCE

Insured Last Name: ____________ First Name: ____________ Middle Initial: ______

Relation to patient: ____________ Birthdate: ____________ Social Security #: ____________

Address (If different from patient): ____________ Home Phone: ____________

City: ____________ State: ______ Zip: ____________

Insured Employed by: ____________ Occupation: ____________

Business Address: ____________ Business Phone: ____________

Insurance Company: ____________ Phone: ____________

Contract #: ____________ Group #: ____________ Subscriber #: ____________

Name of other dependents under this plan: ______________________________

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name: ____________ Relation to patient: ____________ Birthday: ____________

Address (if different from patient): ____________ Social Security #: ____________

City: ____________ State: ______ Zip: ____________ Phone: ____________

Subscriber Employed by: ____________ Business Phone: ____________

Insurance Company: ____________ Phone: ____________

Contract #: ____________ Group #: ____________ Subscriber #: ____________

Name of other dependents under this plan: ______________________________