



Patient Medical History

Physician _____ Office Phone _____ Date of last Exam _____

1. Are you under medical treatment now?	<input type="checkbox"/>	<input type="checkbox"/>	10. Are you wearing contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	11. Are you allergic to or have you had any reactions to the following?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain _____			Local Anesthetics (e.g. Novocain)	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medication(s) including non-prescription medicine?	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or any other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what medication(s) are you taking? _____			Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever taken Fen-Phen/Redux?	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	<input type="checkbox"/>	<input type="checkbox"/>	Iodine	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you use controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>	Any Metals (e.g. nickel, mercury, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have or have you had any of the following?			Latex Rubber	<input type="checkbox"/>	<input type="checkbox"/>
Yes No			Other (please list) _____	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	13. Women Only:		
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	a) Are you pregnant or think you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	b) Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Fainting / Seizures	<input type="checkbox"/>	<input type="checkbox"/>	c) Are you taking oral contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Yes No		
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy / Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever / Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>			
Cancer	<input type="checkbox"/>	<input type="checkbox"/>			
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>			
Joint Replacement or Implant	<input type="checkbox"/>	<input type="checkbox"/>			
Hepatitis / Jaundice	<input type="checkbox"/>	<input type="checkbox"/>			
Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Stomach Troubles / Ulcers	<input type="checkbox"/>	<input type="checkbox"/>			

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

1. Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>	8. Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel pain to any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had any difficult extractions in the past?	<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"/>	12. Have you ever had any prolonged bleeding following extractions?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you had any orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever experienced any of the following problems in your jaw?			14. Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>
Clicking	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of placement _____		
Pain (joint, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you like your smile?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing	<input type="checkbox"/>	<input type="checkbox"/>			

Authorization and Release

Payment is due in full at the time of treatment unless prior arrangements have been approved.

This office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.

I understand that the information that 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 the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

X

Signature of patient (or parent/guardian if minor) _____ Date _____



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 your dental healthcare needs, please fill out
 this form completely in ink. If you have any questions or need
 assistance, please ask us - we will be happy to help.

Patient # _____
 SS#/SIN _____
 Date _____
 Patient's Sex F M
 Home Phone _____
 State/Prov. _____ Zip/P.C. _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____
 Address _____ City _____
 Email _____ Cell Phone _____

Do you prefer to receive calls at your: Home Work Cell Phone
 Check Appropriate Box: Minor Single Married Divorced Widowed Separated
 If Student, Name of School/College _____ City _____ State/Prov. _____ Full Time Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____
 Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____
 Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____
 Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
 Address _____ Home Phone _____
 Email _____ Cell Phone _____

Driver's License# _____ Birthdate _____ Financial Institution _____
 Employer _____ Work Phone _____ SS#/SIN _____

Is this Person Currently a Patient in our Office? Yes No
 For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
 Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____
 Birthdate _____ SS#/SIN _____ Date Employed _____
 Name of Employer _____ Union or local # _____ Work Phone _____
 Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
 Insurance Company _____ Group # _____ Policy/ID# _____
 Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
 How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
 Birthdate _____ SS#/SIN _____ Date Employed _____
 Name of Employer _____ Union or local # _____ Work Phone _____
 Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
 Insurance Company _____ Group # _____ Policy/ID# _____
 Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
 How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____