

*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. if you have any questions or need assistance, please ask -  
 we are happy to help.

## Patient Information (CONFIDENTIAL)

Patient # \_\_\_\_\_  
 SS#/SIN \_\_\_\_\_  
 Date \_\_\_\_\_  
 Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Email \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Check Appropriate Box    Minor    Single    Married    Divorced    Widowed    Separated  
 If Student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Full Time    Part Time  
 Patient or Parent/Guardian's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 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 your 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 \_\_\_\_\_ ZIP \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID# \_\_\_\_\_  
 Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 How Much is your Deductable? \_\_\_\_\_ How Much Have You Used? \_\_\_\_\_ Max Annual Benefit \_\_\_\_\_

DO YOU HAVE ANY ADDITIONAL INSURANCE?	Yes	No	IF YES, COMPLETE THE FOLOWING
Name of Insured _____			Relationship to Patient _____
Birthdate _____ SS#/SIN _____			Date Employed _____
Name of Employer _____ Union or Local # _____			Work Phone _____
Address of Employer _____ City _____			State _____ ZIP _____
Insurance Company _____ Group # _____			Policy/ID# _____
Ins. Co. Address _____ City _____			State _____ ZIP _____
How Much is your Deductable? _____ How Much Have You used? _____			Max Annual Benefit _____

# Patient Medical History

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

- |  |                                    |    |                           |                     |                    |                         |                       |                    |                      |              |                           |                        |              |              |                          |                 |                              |              |                |                 |                |                                    |                       |                            |                             |                                    |                       |                                 |  |  |           |   |  |   |  |                   |  |                   |  |                 |  |              |  |               |  |   |  |                    |  |                           |  |
|--|------------------------------------|----|---------------------------|---------------------|--------------------|-------------------------|-----------------------|--------------------|----------------------|--------------|---------------------------|------------------------|--------------|--------------|--------------------------|-----------------|------------------------------|--------------|----------------|-----------------|----------------|------------------------------------|-----------------------|----------------------------|-----------------------------|------------------------------------|-----------------------|---------------------------------|--|--|-----------|---|--|---|--|-------------------|--|-------------------|--|-----------------|--|--------------|--|---------------|--|---|--|--------------------|--|---------------------------|--|
| <p>1. Are you under medical treatment now? .....</p> <p>2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? .....<br/>If yes, please explain _____</p> <p>3. Are you taking any medication(s) including non-prescription medicine? .....<br/>If yes, what medication(s) are you taking? _____</p> <p>4. Have you ever taken Fen-Phen/Redux? .....</p> <p>5. Do you use tobacco? .....</p> <p>6. Do you use controlled substances? .....</p> <p>7. Are you wearing contact lenses? .....</p> <p>8. Do you have or have had any of the following?</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%; text-align: center;">Yes</td> <td style="width: 50%; text-align: center;">No</td> </tr> <tr> <td>High Blood Pressure .....</td> <td>Heart Disease .....</td> </tr> <tr> <td>Heart Attack .....</td> <td>Cardiac Pacemaker .....</td> </tr> <tr> <td>Rheumatic Fever .....</td> <td>Heart Murmur .....</td> </tr> <tr> <td>Swollen Ankles .....</td> <td>Angina .....</td> </tr> <tr> <td>Fainting / Seizures .....</td> <td>Frequently Tired .....</td> </tr> <tr> <td>Asthma .....</td> <td>Anemia .....</td> </tr> <tr> <td>Low Blood Pressure .....</td> <td>Emphysema .....</td> </tr> <tr> <td>Epilepsy / Convulsions .....</td> <td>Cancer .....</td> </tr> <tr> <td>Leukemia .....</td> <td>Arthritis .....</td> </tr> <tr> <td>Diabetes .....</td> <td>Joint Replacement or Implant .....</td> </tr> <tr> <td>Kidney Diseases .....</td> <td>Hepatitis / Jaundice .....</td> </tr> <tr> <td>AIDS or HIV Infection .....</td> <td>Sexually Transmitted Disease .....</td> </tr> <tr> <td>Thyroid Problem .....</td> <td>Stomach Troubles / Ulcers .....</td> </tr> </table> | Yes                                | No | High Blood Pressure ..... | Heart Disease ..... | Heart Attack ..... | Cardiac Pacemaker ..... | Rheumatic Fever ..... | Heart Murmur ..... | Swollen Ankles ..... | Angina ..... | Fainting / Seizures ..... | Frequently Tired ..... | Asthma ..... | Anemia ..... | Low Blood Pressure ..... | Emphysema ..... | Epilepsy / Convulsions ..... | Cancer ..... | Leukemia ..... | Arthritis ..... | Diabetes ..... | Joint Replacement or Implant ..... | Kidney Diseases ..... | Hepatitis / Jaundice ..... | AIDS or HIV Infection ..... | Sexually Transmitted Disease ..... | Thyroid Problem ..... | Stomach Troubles / Ulcers ..... | <p style="text-align: center;">Yes    No</p> <p>9. Are you allergic to or have you had any reactions to the following</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;"></td> <td style="width: 50%; text-align: center;">Yes    No</td> </tr> <tr> <td>Local Anesthetics (e.g. Novocain) .....</td> <td></td> </tr> <tr> <td>Penicillin or any other Antibiotics .....</td> <td></td> </tr> <tr> <td>Sulfa Drugs .....</td> <td></td> </tr> <tr> <td>Barbituates .....</td> <td></td> </tr> <tr> <td>Sedatives .....</td> <td></td> </tr> <tr> <td>Iodine .....</td> <td></td> </tr> <tr> <td>Aspirin .....</td> <td></td> </tr> <tr> <td>Any Metals (e.g. nickel, mercury, etc.) .....</td> <td></td> </tr> <tr> <td>Latex Rubber .....</td> <td></td> </tr> <tr> <td>Other (Please list) _____</td> <td></td> </tr> </table> <p>10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)</p> <p>11. Women Only:</p> <p>a) Are you pregnant or think you may be pregnant? .....</p> <p>b) Are you nursing? .....</p> <p>c) Are you taking oral contraceptives? .....</p> |  | Yes    No | Local Anesthetics (e.g. Novocain) ..... |  | Penicillin or any other Antibiotics ..... |  | Sulfa Drugs ..... |  | Barbituates ..... |  | Sedatives ..... |  | Iodine ..... |  | Aspirin ..... |  | Any Metals (e.g. nickel, mercury, etc.) ..... |  | Latex Rubber ..... |  | Other (Please list) _____ |  |
| Yes  | No                                 |    |                           |                     |                    |                         |                       |                    |                      |              |                           |                        |              |              |                          |                 |                              |              |                |                 |                |                                    |                       |                            |                             |                                    |                       |                                 |  |  |           |   |  |   |  |                   |  |                   |  |                 |  |              |  |               |  |   |  |                    |  |                           |  |
| High Blood Pressure .....  | Heart Disease .....                |    |                           |                     |                    |                         |                       |                    |                      |              |                           |                        |              |              |                          |                 |                              |              |                |                 |                |                                    |                       |                            |                             |                                    |                       |                                 |  |  |           |   |  |   |  |                   |  |                   |  |                 |  |              |  |               |  |   |  |                    |  |                           |  |
| Heart Attack .....   | Cardiac Pacemaker .....            |    |                           |                     |                    |                         |                       |                    |                      |              |                           |                        |              |              |                          |                 |                              |              |                |                 |                |                                    |                       |                            |                             |                                    |                       |                                 |  |  |           |   |  |   |  |                   |  |                   |  |                 |  |              |  |               |  |   |  |                    |  |                           |  |
| Rheumatic Fever .....  | Heart Murmur .....                 |    |                           |                     |                    |                         |                       |                    |                      |              |                           |                        |              |              |                          |                 |                              |              |                |                 |                |                                    |                       |                            |                             |                                    |                       |                                 |  |  |           |   |  |   |  |                   |  |                   |  |                 |  |              |  |               |  |   |  |                    |  |                           |  |
| Swollen Ankles .....   | Angina .....                       |    |                           |                     |                    |                         |                       |                    |                      |              |                           |                        |              |              |                          |                 |                              |              |                |                 |                |                                    |                       |                            |                             |                                    |                       |                                 |  |  |           |   |  |   |  |                   |  |                   |  |                 |  |              |  |               |  |   |  |                    |  |                           |  |
| Fainting / Seizures .....  | Frequently Tired .....             |    |                           |                     |                    |                         |                       |                    |                      |              |                           |                        |              |              |                          |                 |                              |              |                |                 |                |                                    |                       |                            |                             |                                    |                       |                                 |  |  |           |   |  |   |  |                   |  |                   |  |                 |  |              |  |               |  |   |  |                    |  |                           |  |
| Asthma .....   | Anemia .....                       |    |                           |                     |                    |                         |                       |                    |                      |              |                           |                        |              |              |                          |                 |                              |              |                |                 |                |                                    |                       |                            |                             |                                    |                       |                                 |  |  |           |   |  |   |  |                   |  |                   |  |                 |  |              |  |               |  |   |  |                    |  |                           |  |
| Low Blood Pressure .....   | Emphysema .....                    |    |                           |                     |                    |                         |                       |                    |                      |              |                           |                        |              |              |                          |                 |                              |              |                |                 |                |                                    |                       |                            |                             |                                    |                       |                                 |  |  |           |   |  |   |  |                   |  |                   |  |                 |  |              |  |               |  |   |  |                    |  |                           |  |
| Epilepsy / Convulsions .....   | Cancer .....                       |    |                           |                     |                    |                         |                       |                    |                      |              |                           |                        |              |              |                          |                 |                              |              |                |                 |                |                                    |                       |                            |                             |                                    |                       |                                 |  |  |           |   |  |   |  |                   |  |                   |  |                 |  |              |  |               |  |   |  |                    |  |                           |  |
| Leukemia .....   | Arthritis .....                    |    |                           |                     |                    |                         |                       |                    |                      |              |                           |                        |              |              |                          |                 |                              |              |                |                 |                |                                    |                       |                            |                             |                                    |                       |                                 |  |  |           |   |  |   |  |                   |  |                   |  |                 |  |              |  |               |  |   |  |                    |  |                           |  |
| Diabetes .....   | Joint Replacement or Implant ..... |    |                           |                     |                    |                         |                       |                    |                      |              |                           |                        |              |              |                          |                 |                              |              |                |                 |                |                                    |                       |                            |                             |                                    |                       |                                 |  |  |           |   |  |   |  |                   |  |                   |  |                 |  |              |  |               |  |   |  |                    |  |                           |  |
| Kidney Diseases .....  | Hepatitis / Jaundice .....         |    |                           |                     |                    |                         |                       |                    |                      |              |                           |                        |              |              |                          |                 |                              |              |                |                 |                |                                    |                       |                            |                             |                                    |                       |                                 |  |  |           |   |  |   |  |                   |  |                   |  |                 |  |              |  |               |  |   |  |                    |  |                           |  |
| AIDS or HIV Infection .....  | Sexually Transmitted Disease ..... |    |                           |                     |                    |                         |                       |                    |                      |              |                           |                        |              |              |                          |                 |                              |              |                |                 |                |                                    |                       |                            |                             |                                    |                       |                                 |  |  |           |   |  |   |  |                   |  |                   |  |                 |  |              |  |               |  |   |  |                    |  |                           |  |
| Thyroid Problem .....  | Stomach Troubles / Ulcers .....    |    |                           |                     |                    |                         |                       |                    |                      |              |                           |                        |              |              |                          |                 |                              |              |                |                 |                |                                    |                       |                            |                             |                                    |                       |                                 |  |  |           |   |  |   |  |                   |  |                   |  |                 |  |              |  |               |  |   |  |                    |  |                           |  |
|  | Yes    No                          |    |                           |                     |                    |                         |                       |                    |                      |              |                           |                        |              |              |                          |                 |                              |              |                |                 |                |                                    |                       |                            |                             |                                    |                       |                                 |  |  |           |   |  |   |  |                   |  |                   |  |                 |  |              |  |               |  |   |  |                    |  |                           |  |
| Local Anesthetics (e.g. Novocain) .....  |                                    |    |                           |                     |                    |                         |                       |                    |                      |              |                           |                        |              |              |                          |                 |                              |              |                |                 |                |                                    |                       |                            |                             |                                    |                       |                                 |  |  |           |   |  |   |  |                   |  |                   |  |                 |  |              |  |               |  |   |  |                    |  |                           |  |
| Penicillin or any other Antibiotics .....  |                                    |    |                           |                     |                    |                         |                       |                    |                      |              |                           |                        |              |              |                          |                 |                              |              |                |                 |                |                                    |                       |                            |                             |                                    |                       |                                 |  |  |           |   |  |   |  |                   |  |                   |  |                 |  |              |  |               |  |   |  |                    |  |                           |  |
| Sulfa Drugs .....  |                                    |    |                           |                     |                    |                         |                       |                    |                      |              |                           |                        |              |              |                          |                 |                              |              |                |                 |                |                                    |                       |                            |                             |                                    |                       |                                 |  |  |           |   |  |   |  |                   |  |                   |  |                 |  |              |  |               |  |   |  |                    |  |                           |  |
| Barbituates .....  |                                    |    |                           |                     |                    |                         |                       |                    |                      |              |                           |                        |              |              |                          |                 |                              |              |                |                 |                |                                    |                       |                            |                             |                                    |                       |                                 |  |  |           |   |  |   |  |                   |  |                   |  |                 |  |              |  |               |  |   |  |                    |  |                           |  |
| Sedatives .....  |                                    |    |                           |                     |                    |                         |                       |                    |                      |              |                           |                        |              |              |                          |                 |                              |              |                |                 |                |                                    |                       |                            |                             |                                    |                       |                                 |  |  |           |   |  |   |  |                   |  |                   |  |                 |  |              |  |               |  |   |  |                    |  |                           |  |
| Iodine .....   |                                    |    |                           |                     |                    |                         |                       |                    |                      |              |                           |                        |              |              |                          |                 |                              |              |                |                 |                |                                    |                       |                            |                             |                                    |                       |                                 |  |  |           |   |  |   |  |                   |  |                   |  |                 |  |              |  |               |  |   |  |                    |  |                           |  |
| Aspirin .....  |                                    |    |                           |                     |                    |                         |                       |                    |                      |              |                           |                        |              |              |                          |                 |                              |              |                |                 |                |                                    |                       |                            |                             |                                    |                       |                                 |  |  |           |   |  |   |  |                   |  |                   |  |                 |  |              |  |               |  |   |  |                    |  |                           |  |
| Any Metals (e.g. nickel, mercury, etc.) .....  |                                    |    |                           |                     |                    |                         |                       |                    |                      |              |                           |                        |              |              |                          |                 |                              |              |                |                 |                |                                    |                       |                            |                             |                                    |                       |                                 |  |  |           |   |  |   |  |                   |  |                   |  |                 |  |              |  |               |  |   |  |                    |  |                           |  |
| Latex Rubber .....   |                                    |    |                           |                     |                    |                         |                       |                    |                      |              |                           |                        |              |              |                          |                 |                              |              |                |                 |                |                                    |                       |                            |                             |                                    |                       |                                 |  |  |           |   |  |   |  |                   |  |                   |  |                 |  |              |  |               |  |   |  |                    |  |                           |  |
| Other (Please list) _____  |                                    |    |                           |                     |                    |                         |                       |                    |                      |              |                           |                        |              |              |                          |                 |                              |              |                |                 |                |                                    |                       |                            |                             |                                    |                       |                                 |  |  |           |   |  |   |  |                   |  |                   |  |                 |  |              |  |               |  |   |  |                    |  |                           |  |

# Patient Dental History

Name of Previous Dentist and Location \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

- |  |                |  |                                       |  |  |  |                             |  |  |
|--|----------------|--|---------------------------------------|--|--|--|-----------------------------|--|--|
| <p style="text-align: center;">Yes    No</p> <p>1. Do your gums bleed while brushing or flossing? .....</p> <p>2. Are your teeth sensitive to hot or cold liquids/foods? .....</p> <p>3. Are your teeth sensitive to sweet or sour liquids/foods? .....</p> <p>4. Do you feel pain to any of your teeth? .....</p> <p>5. Do you have any sores or lumps in or near your mouth? .....</p> <p>6. Have you have any head, neck or jaw injuries? .....</p> <p>7. Have you ever experienced any of the following problems in your jaw?</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">Clicking .....</td> <td style="width: 50%;"></td> </tr> <tr> <td>Pain (joint, ear, side of face) .....</td> <td></td> </tr> <tr> <td>Difficulty in opening or closing .....</td> <td></td> </tr> <tr> <td>Difficulty in chewing .....</td> <td></td> </tr> </table> | Clicking ..... |  | Pain (joint, ear, side of face) ..... |  | Difficulty in opening or closing ..... |  | Difficulty in chewing ..... |  | <p style="text-align: center;">Yes    No</p> <p>8. Do you have frequent headaches? .....</p> <p>9. Do you clench or grind your teeth? .....</p> <p>10. Do you bite your lips or cheeks frequently? .....</p> <p>11. Have you ever had any difficult extractions in the past? .....</p> <p>12. Have you ever had any prolonged bleeding following extractions? .....</p> <p>13. Have you had any orthodontic treatment? .....</p> <p>14. Do you wear dentures or partials? .....</p> <p style="padding-left: 20px;">If yes, date of placement _____</p> <p>15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? .....</p> <p>16. Do you like your smile? .....</p> |
| Clicking .....   |                |  |                                       |  |  |  |                             |  |  |
| Pain (joint, ear, side of face) .....  |                |  |                                       |  |  |  |                             |  |  |
| Difficulty in opening or closing .....   |                |  |                                       |  |  |  |                             |  |  |
| Difficulty in chewing .....  |                |  |                                       |  |  |  |                             |  |  |

# 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 payors and/or health practitioners. I authorize and request my insurance company 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 bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X \_\_\_\_\_  
Signature of patient (or parent/guardian if minor)

Doctor's Comments _____
<div style="display: flex; justify-content: space-between;"> <span>Signature _____</span> <span>Date _____</span> </div>