



# 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

## Patient Information (CONFIDENTIAL)

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
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 \_\_\_\_\_

Over Please



# Patient Medical History

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

- |   |                              |                             |  |                              |                             |
|---|------------------------------|-----------------------------|--|------------------------------|-----------------------------|
| 1. Are you under medical treatment now? .....   | Yes <input type="checkbox"/> | No <input type="checkbox"/> | 10. Are you wearing contact lenses? .....  | Yes <input type="checkbox"/> | No <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?  |                              |                             |
| 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, Revati, 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"/>    |
|   |                              |                             | Other _____  |                              |                             |
|   |                              |                             | 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"/>    |
|   |                              |                             | 13. Women Only:  |                              |                             |
|   |                              |                             | a) Are you pregnant or think you may be pregnant? .....  | <input type="checkbox"/>     | <input type="checkbox"/>    |
|   |                              |                             | b) Are you nursing? .....  | <input type="checkbox"/>     | <input type="checkbox"/>    |
|   |                              |                             | c) Are you taking oral contraceptives? .....   | <input type="checkbox"/>     | <input type="checkbox"/>    |

High Blood Pressure .....	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Heart Disease .....	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Chest Pains .....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart Attack .....	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker .....	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded .....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever .....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur .....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke .....	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles .....	<input type="checkbox"/>	<input type="checkbox"/>	Angina .....	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever / Allergies .....	<input type="checkbox"/>	<input type="checkbox"/>
Fainting / Seizures .....	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired .....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis .....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>	Anemia .....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy .....	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema .....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma .....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy / Convulsions .....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer .....	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss .....	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia .....	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant .....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble .....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases .....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis / Jaundice .....	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems .....	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection .....	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse .....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem .....	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles / Ulcers .....	<input type="checkbox"/>	<input type="checkbox"/>	Other .....	<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? .....                 | Yes <input type="checkbox"/> | No <input type="checkbox"/> | 8. Do you have frequent headaches? .....  | Yes <input type="checkbox"/> | No <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** \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of patient (or parent/guardian if minor)