Patient Information

Name: _____ Preferred Name: _____

Home Address: _____ City: _____ State _____ Zip: _____

Home #: _____ Work #: _____ Mobile #: _____

Email: _____

Sex: M / F Birth Date: ___ /___ /_____ SS#:_____

Family Status (circle): Single Married Divorced Child Spouse's Name: _____

How did you first hear about our office? (circle one):

Another Patient	Another Dental Office	Brochure	Online Search
Facebook	Work	School	Insurance Website
Sign –Drive by	Walk in	Other:_____	

Whom may we thank for referring you to our practice?_____

Person Responsible for Account

Name of responsible party: _____

Relationship to patient (Circle): Self Spouse Parent Other: _____

Home Address: _____ City: _____ State: _____Zip: _____

Home #: _____Work #: _____ Mobile #: _____

Email: _____

Birth Date: ___ /___ /_____ SS#:_____

Contact Information

What is the best way to communicate with you? Home Phone / Mobile Phone/ Text / Email

In the event of an emergency, whom should we contact? Name _____

Relationship_____ Home #: _____ Work #: _____ Mobile #: _____

Insurance Information (Primary)

Name of Insured: _____ Relationship to patient: _____

Insured Birth Date: ___ /___ /_____

Insurance Plan Name: _____ Insurance Co Phone #: _____

Claims Address _____

City, State, Zip _____

Group #: _____ ID #: _____

Insurance Information (Secondary)

Name of Insured: _____ Relationship to patient: _____

Insured Birth Date: ___ /___ /_____

Insurance Plan Name: _____ Insurance Co Phone #:_____

Claims Address _____

City, State, Zip _____

Group #: _____ ID #: _____

Employment Information

Employer Name: _____ Phone: _____

Address: _____

City, State, Zip: _____

Cancellations and Missed Appointments

We require 48 hours advance notice of a cancellation. Patients who do not provide 48 hours notice of a cancellation or who do not present for a scheduled appointment may be charged a fee of $50. Patients who fail to present for a second appointment may be dismissed from the practice.

I have read the Cancellation and Missed Appointment Policy. I understand and agree to this Policy.

Patient Signature_____Date_____

Medical History

Patient Name: _____ Date of Birth: _____

1. Date of last physical exam: _____ Physician's Name: _____
Physician's Phone#: _____
2. Have you ever been hospitalized (if yes, explain below)? Yes No
_____
3. Have you been under the care of a medical doctor during the past two years? Yes No
If yes, what for? _____
4. Have you ever had any excessive bleeding requiring special treatment? Yes No
5. Women: Are you pregnant/trying to get pregnant/breast feeding? Yes No

6. Are you allergic to or have you had an allergic reaction to any of the following (please circle if yes):

Local Anesthetic	Penicillin	Codeine	Other Antibiotic: _____
Latex	Acrylic	Metals	Other:_____

7. Are you taking or have you ever taken any of the following medications (please circle if yes):

Fosamax	Actonel	Boniva	For how long? _____
Aredia	Reclast	Zometa	When did you stop? _____

8. Please list other medications you are taking:
_____
_____

Have you ever had any of the following?

Chest Pains	Yes	No	Shortness of Breath	Yes	No	Hives/Skin Rashes	Yes	No
Heart Failure	Yes	No	Ulcers	Yes	No	Alcoholism	Yes	No
Heart Disease	Yes	No	Mental Health Issues	Yes	No	Herpes	Yes	No
Heart Attack	Yes	No	Emphysema	Yes	No	Glaucoma	Yes	No
Heart Problems	Yes	No	Fainting/Dizziness	Yes	No	Steroid Treatment	Yes	No
Angina Pectoris	Yes	No	Eating Disorder	Yes	No	Arthritis	Yes	No
Heart Surgery	Yes	No	Epilepsy/Seizures	Yes	No	Dental Implant	Yes	No
Liver Disease	Yes	No	Persistent Cough	Yes	No	Dentures/Partials	Yes	No
Hypertension	Yes	No	Tuberculosis	Yes	No	Birth Defects	Yes	No
Heart Murmur	Yes	No	Asthma	Yes	No	HIV+, AIDS, ARC	Yes	No
Rheumatic Fever	Yes	No	Hepatitis A	Yes	No	Hay Fever	Yes	No
Psychiatric Treatment	Yes	No	Hepatitis B	Yes	No	Tobacco Products	Yes	No

Sickle Cell Disease	Yes	No	Hepatits C or D	Yes	No	Bruise Easily	Yes	No
Sinus Trouble	Yes	No	Pacemaker	Yes	No	Jaundice	Yes	No
Artificial Joints	Yes	No	Night Sweats	Yes	No	Kidney Trouble	Yes	No
Thyroid Disease	Yes	No	Stroke	Yes	No	Diabetes	Yes	No
Anemia	Yes	No	Drug Addiction	Yes	No	Chemotherapy	Yes	No
Blood Transfusion	Yes	No	Cold Sores	Yes	No	Cancer	Yes	No
Mitral Valve Prolapse (MVP)	Yes	No	Radiation Therapy	Yes	No	Transplant	Yes	No

Dental History

1. Date of last dental exam:_____ Date of last dental x-rays: _____
2. Previous dentist's name / location:_____
3. Are you having tooth or gum pain at this time? Yes No
4. Do you feel nervous about having dental treatment? Yes No
5. Have you ever had a bad experience in a dental office? Yes No
6. Do your gums bleed when brushing / flossing? Yes No
7. Have you ever seen a periodontist? Yes No
8. Have you ever had a "deep cleaning" (Scaling and Root Planing)? Yes No
9. Is there anything you would like to speak with the Doctor about in private? Yes No
10. Would you be interested in discussing ways to improve your smile? Yes No

If yes, please explain: _____

Do you have any of the following dental concerns:

Clicking in jaw joint	Yes	No	Sensitivity to:	Hot	Cold	Sweets	Biting
Pain in or around your ears	Yes	No	Swelling		Bleeding Gums		
Difficulty opening or closing	Yes	No	Bad Taste		Bad Breath		
Difficulty chewing	Yes	No	Food Catching		Tooth Pain		
History of trauma to jaw or face	Yes	No	Clenching		Grinding		
Diagnosis of TMJ/TMD	Yes	No	Other: _____				

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

Signature: _____ Date_____

Doctor's Signature_____

Doctor's Notes: