



Welcome to our office

About You

Patient Name _____ Today's Date _____

_____ Last _____ First _____ M

What You Prefer to be Called _____

Birthdate _____ Age _____

Social Security # _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone # _____

Work Phone # _____

Cell Phone # _____

e-mail Address _____

Referred By _____

Employer _____

How Long? _____

Employer's Address _____

City _____ State _____ Zip _____

Occupation _____

Status: Single ___ Married ___ Divorced ___ Widowed ___

Spouse's Name _____

Do you have children? Yes ___ No ___ How many? _____

Account Information

Person responsible for account

Name _____

Relationship _____

Billing Address _____

City _____ State _____ Zip _____

Social Security # _____

Drivers License # _____

Work Phone # _____

Home Phone # _____

Insurance Information

Primary Dental Insurance

Insurance Carrier _____

Group Plan # _____

Phone # _____

Insured's Name _____

Relation _____

Date of Birth _____

Insured's SS# _____

Insured's Employer _____

Secondary Dental Insurance

Insurance Carrier _____

Group Plan # _____

Phone # _____

Insured's Name _____

Relation _____

Date of Birth _____

Insured's SS# _____

Insured's Employer _____

In Event of Emergency

Who should we contact? _____

Relationship: _____

Home Phone # _____

Work Phone # _____

Cell Phone # _____

Who is your MEDICAL DR.? _____

M.D.'s Phone # _____

Please continue on back →



Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check (✓) yes or no if you have had problems with any of the following:

<input type="checkbox"/> Y <input type="checkbox"/> N Bad breath	<input type="checkbox"/> Y <input type="checkbox"/> N Food collection between teeth	<input type="checkbox"/> Y <input type="checkbox"/> N Periodontal treatment	<input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets
<input type="checkbox"/> Y <input type="checkbox"/> N Bleeding gums	<input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching teeth	<input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to cold	<input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting
<input type="checkbox"/> Y <input type="checkbox"/> N Clicking or popping jaw	<input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth or broken fillings	<input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to hot	<input type="checkbox"/> Y <input type="checkbox"/> N 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, describe _____

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

Have you ever taken Fen-Phen/Redux? Y N

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. Y N

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

Check (✓) yes or no whether you have had any of the following:

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

Is patient currently taking any medications? If yes, list all: _____

Does patient have drug allergies? If yes, list all: _____

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 dentist.

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 payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

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