Thank you for selecting our dental team! We will strive to provide you with the best possible care. To help us meet all your dental needs, please fill out this form completely. If you have any questions or need assistance, please ask us and we will be happy to help!

Patient Information

Name____ Birthdate________________ Primary Phone____________________________
Address____ City___________________ State/Prov._____ Zip______________
Email____ Check Appropriate Box ☐Minor ☐ Single ☐ Married
Preferred method of Contact ___ Phone ___ Email
If Student, Name of School / College_______________________________ F.T. ___ P.T. ___ City__________________ State/Prov_____
Patient's or Parent's Employer____ Work Phone ______________________
Business Address____ City__________________ State/Prov. _____ Zip______________
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____
Driver's License # _____________________________________ Birthdate _________________Financial Institution_________________
Employer______________________________________ Work Phone____________________ SSN#________________________
Is this Person Currently a Patient in our Office? ☐Yes ☐No

Insurance Information

Name of Insured____ Relationship to Patient_______________
Birthdate________________________ SSN ____________________________________ Date Employed ___________________________
Name of Employer ____ Work Phone ____________________________
Address of Employer _____________________________________ City______________________ State/Prov___________ Zip________
Insurance Company ______________________________________ Group # _____________________ Policy ID#__________________
Ins. Co. Address ____ City________________________ State/Prov__________ Zip________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐Yes ☐No **IF YES, COMPLETE THE FOLLOWING**:
Name of Insured____ Relationship to Patient_______________
Birthdate________________________ SSN ____________________________________ Date Employed ___________________________
Name of Employer ____ Work Phone ____________________________
Address of Employer _____________________________________ City______________________ State/Prov___________ Zip________
Insurance Company ______________________________________ Group # _____________________ Policy ID#__________________
Ins. Co. Address ____ City________________________ State/Prov__________ Zip________

Patient Medical History

Physician ______________________ Office Phone ______________________ Date of Last Exam ______________________

		Yes	No
1)	Are you under medical treatment now?	___	___
	a. If so, what for? ______________________		
2)	Have you ever been hospitalized for surgery or serious illness within the last 5 years?	___	___
	a. If Yes, please elaborate: ______________________		
3)	Do you require prophylactic antibiotics before dental treatment?	___	___
4)	Are you taking any medications including non-prescription medicines?	___	___
	a. If Yes, please list your medications: ______________________		
5)	Have you ever taken Phen-Fen/Redux?	___	___
6)	Do you use tobacco products/vape?	___	___
7)	Do you use controlled substances?	___	___
8)	Are you allergic to any of the following?:		
	a. Local Anesthetics (e.g. Novocaine)	___	___
	b. Penicillin or other Antibiotics	___	___
	c. Sulfa Drugs	___	___
	d. Barbiturates/Sedatives	___	___
	e. Metals (nickel, mercury, etc.)	___	___
	f. Latex	___	___
	g. Aspirin	___	___
	h. Ibuprofen	___	___
	i. Other: ______________________		
9)	Do you have or have you had any of the following?:		
	a. High Blood Pressure	___	___
	b. Low Blood Pressure	___	___
	c. Heart Disease	___	___
	d. Mitral Valve Prolapse	___	___
	e. Other heart defects: ______________________		
	f. Rheumatic Fever	___	___
	g. Chest Pains	___	___
	h. Heart Attack	___	___
	i. Cardiac Pacemaker	___	___
	j. Easily Winded	___	___
	k. Heart Murmur	___	___
	l. Stroke	___	___
	m. Swollen Ankles	___	___
	n. Hay Fever/Allergies	___	___
	o. Asthma	___	___
	p. Emphysema	___	___
	q. Tuberculosis	___	___
	r. Fainting/Seizures	___	___
	s. Anemia	___	___
	t. Cancer	___	___
	u. Radiation Therapy	___	___
	v. Glaucoma	___	___
	w. Arthritis	___	___
	x. Joint Replacement	___	___
	y. Liver Disease	___	___
	z. Kidney Disease	___	___
	aa. Diabetes	___	___
	bb. Thyroid Problems	___	___
	cc. Stomach Problems/Ulcers	___	___
	dd. HIV/AIDS	___	___
	ee. STDs	___	___

Yes No

10) Women Only:
    a. Are you pregnant or think you may be pregnant?.. ___ ___
    b. Are you nursing?.. ___ ___
    c. Are you taking oral contraceptives?.. ___ ___

Patient Dental History

Name of Previous Dentist & Location____ Date of Last Exam__________

Yes No

1) Are you having any pain with your teeth?... ___ ___
2) Are your teeth sensitive to any of the following?:
    a. Hot.. ___ ___
    b. Cold.. ___ ___
    c. Sweet.. ___ ___
    d. Pressure.. ___ ___
3) Do your gums bleed while brushing/flossing?.. ___ ___
4) Does food or floss catch between your teeth?.. ___ ___
5) Have you ever received gum/periodontal treatments?... ___ ___
6) Do you have any sores or lumps in/around your mouth?.. ___ ___
7) Are you experiencing any pain, clicking/popping, or limited opening with your jaw?.............................. ___ ___
8) Do you have frequent headaches?... ___ ___
9) Do you clench/grind your teeth?... ___ ___
10) Have you ever had a difficult tooth extraction?... ___ ___
11) Have you ever had prolonged bleeding associated with a tooth extraction?.. ___ ___
12) Do you wear dentures/partial dentures?.. ___ ___
13) Have you ever had orthodontic treatment?.. ___ ___
14) Are you interested in whitening?... ___ ___
15) Is there anything you would like to change about your teeth/smile?... ___ ___
    a. If so, please elaborate: ____
    ____

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 dentists 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 if minor)