

Welcome to our practice

Please take your time to fill out this form completely. The more we learn about you, the better care we are able to provide. We look forward to working with you to maintain a healthy happy smile.

Patient Information

Today's date _____

First Name _____ Middle Initial _____ Last Name _____

I prefer to be called (nickname, etc.) _____ Male _____ Female _____

Address _____ City _____ State _____ ZIP _____

Date of birth _____ Social Security Number _____

Home phone (____) _____ - _____ Work phone (____) _____ - _____ Cell phone (____) _____ - _____

Primary contact number (please check one) Home _____ Office _____ Cell _____ Best time to call _____

Fax (____) _____ - _____ Email _____ Drivers license # _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's Occupation _____

Whom may we thank for referring you? _____

If the patient is a child

School _____ School phone (____) _____ - _____ Grade _____

Dental History

Reason for today's visit _____ Relationship to patient _____

Are you currently in pain? Yes No

If so, please describe: _____

Do you have any dental problems now? Yes No

If so, please describe: _____

Have you ever had trouble with a previous dental treatment? Yes No

If so, please describe: _____

Level of anxiety about seeing the dentist _____ (Least) 1 2 3 4 5 (Most)

Date of last dental exam _____ Date of last cleaning _____ Date of last full mouth X-Rays _____

Procedure(s) done at last dental visit _____

Previous dentist's name _____

City _____ State _____ phone (____) _____ - _____

Why are you changing dentists? _____

How often do you have dental examinations? _____ How often do you brush your teeth? _____

How often do you floss? _____ What type of bristles do you use? Hard Medium Soft

What other dental aids do you use? (Electric toothbrush, toothpick, etc.) _____

Do you require antibiotics before dental treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have frequent headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do your gums ever bleed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you clench or grind your teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you noticed any mouth odors or bad taste?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are your teeth sensitive to heat/cold?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you bite your lips or cheeks frequently?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you still have your wisdom teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever had:

- Periodontal disease/gum treatment Yes No
- Orthodontics treatment Yes No
- Oral surgery Yes No
- A bite plate or mouth guard Yes No

Have you ever had:

- Discomfort in your jaw joint (TMJ/TMD) Yes No
- Your teeth ground or bite adjusted Yes No
- Serious injury to the mouth or head Yes No
- Bad Experience in a dental office Yes No

If yes to any of the previous questions, please describe _____
 Is there anything else about your past dental treatment(s) that you would like us to know? _____

Patient Information

Have you been hospitalized or under the care of a medical doctor during the past two years? Yes No

If yes, for what? _____
 Hospital or Physician's name _____ Phone (____) _____ - _____

Have you taken any medications or drugs in the past two years? Yes No

Are you currently taking any medications or drugs? Yes No
 (example: blood thinners, blood pressure meds, antibiotics, aspirin, herbs)

If yes, please explain _____

**Have you ever taken Fen-Phen (Diet Drug),
 Bisphosphonates medication for osteoporosis like Fosamax, Boniva...?** Yes No

If yes, please explain _____

Do you use tobacco in any form? Yes No

Do you use alcohol or any other controlled substance? Yes No

Women Only:

Are you pregnant or thinking you may be pregnant? Yes No

Are you nursing? Yes No

Are you taking birth control pills? Yes No

Indicate which of the following you have had or have at present:

- | | | |
|--|---|---|
| AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No | Diet (Special/Restricted) <input type="checkbox"/> Yes <input type="checkbox"/> No | Lupus <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcohol/Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficulty Breathing <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies or Hives <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervousness/Anxiety <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy or Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No | Neurological Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or Dizzy Spells <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric/Psychological Care <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Bones/Joints <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic/Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No | Shingles/Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart (Surgery, Disease, Attack) <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease/Traits <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bruise Easily <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No | Snoring/Sleep Apnea <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer/Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia/Abnormal Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach Problems/Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pain <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A B C (circle) <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cold Sores/Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No | High/Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Ankles <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Colitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Hospitalized for Any Reason <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Contact Lenses <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis (TB) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease/STD/HPV <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please list any serious medical condition(s) that you have ever had not listed above:

Are you aware of having an allergic (or adverse) reaction of the following:

- | | | |
|---|--|---|
| Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No | Iodine <input type="checkbox"/> Yes <input type="checkbox"/> No | Sedatives <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Codeine <input type="checkbox"/> Yes <input type="checkbox"/> No | Jewelry/Metals <input type="checkbox"/> Yes <input type="checkbox"/> No | Sulfa Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anesthetics (i.e. Novocaine) <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex <input type="checkbox"/> Yes <input type="checkbox"/> No | Tetracycline <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Erythromycin <input type="checkbox"/> Yes <input type="checkbox"/> No | Penicillin or other antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No | Phosphoric Acid <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleach <input type="checkbox"/> Yes <input type="checkbox"/> No | Silver/Gold <input type="checkbox"/> Yes <input type="checkbox"/> No | Methyl Methacrylate <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No | Mercury <input type="checkbox"/> Yes <input type="checkbox"/> No | Zinc Oxide Eugenol <input type="checkbox"/> Yes <input type="checkbox"/> No |
| BPA <input type="checkbox"/> Yes <input type="checkbox"/> No | Cobalt-Chrom <input type="checkbox"/> Yes <input type="checkbox"/> No | Mineral Trioxide Aggregate <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kadmium <input type="checkbox"/> Yes <input type="checkbox"/> No | Acrylic <input type="checkbox"/> Yes <input type="checkbox"/> No | Calcium Hydroxide <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Nickel <input type="checkbox"/> Yes <input type="checkbox"/> No | EDTA (ethylenediaminetetraacetic) <input type="checkbox"/> Yes <input type="checkbox"/> No | Gutta Percha <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Resins <input type="checkbox"/> Yes <input type="checkbox"/> No | Formaldehyde <input type="checkbox"/> Yes <input type="checkbox"/> No | Nsaids (Ibuprofen) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> Other _____ |

Patient Signature _____

Dental Insurance

Primary Carrier

Insurance co. name _____ Insurance co. phone (____) _____ - _____
 Address (Street, City, State, ZIP) _____

Group no. (Plan or Policy no.) _____ Insured's I.D. no. _____
 Insured's name _____ Relationship to patient _____
 Date of birth _____ Insured social security no. _____
 Insured employer name _____ Is insured a patient in our practice? Yes No

Secondary Carrier

Insurance co. name _____ Insurance co. phone (____) _____ - _____
 Address (Street, City, State, ZIP) _____

Group no. (Plan or Policy no.) _____ Insured's I.D. no. _____
 Insured's name _____ Relationship to patient _____
 Date of birth _____ Insured social security no. _____
 Insured employer name _____ Is insured a patient in our practice? Yes No

Person Financially Responsible for Account

Name _____ Relationship to patient _____
 Social security no. _____ Phone (____) _____ - _____
 Drivers license no. _____ Date of birth _____
 Address (Street, City, State, ZIP) _____
 Employer _____ Work phone (____) _____ - _____
 Preferred payment method Cash Credit Card
 Visa/MC/AMEX no. _____ Exp. date _____
 If patient is a minor, name of parent or legal guardian and relationship _____
 Is this parent or legal guardian currently a patient in our office? Yes No

Payment is due in full at the time of treatment
 (Unless prior arrangements have been approved)

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 the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency that may release such information to you.
 I will notify the dentist of any changes in my health or medication.*

Signature _____ Date _____

Person to contact in case of emergency

Name _____ Relationship to patient _____
 City _____ State _____ Cell Phone (____) _____ - _____
 Home Phone (____) _____ - _____ Work Phone (____) _____ - _____

OFFICE USE ONLY

I VERBALLY REVIEWED THE MEDICAL/DENTAL INFORMATION ABOVE WITH THE PATIENT NAMED HEREIN.

Date _____ Initials _____

Today's Date _____

Patient Number _____

- 1. Do you love the way your smile looks? Yes No
- 2. Do you feel comfortable showing your teeth when you laugh or smile? Yes No
- 3. If you could change anything about your smile, it would be (Check all that apply):
 - Color of your teeth Too much or too little of teeth show when you smile Gaps between your teeth
 - Size/Shape of your teeth Too much or too little of gum shows when you smile Alignment of your teeth
 - Other: _____
- 4. Do you have (Check all that apply):
 - Sensitive or receding gums Worn/broken/chpped teeth Missing teeth
 - Old or discolored fillings Old crowns that have dark edges at the top
 - Other: _____
- 5. In your line of work or lifestyle, do you (Check all that apply):
 - Visit businesses or clients Travel Speak publicly
 - Other: _____
- 6. If you had a smile makeover do you think you'd feel (Check all that apply):
 - More confident More optimistic Healthier
 - Just OK No different Other: _____
- 7. Do you or someone in your family have issues with any of the following (Check all that apply):
 - Chronic bad breath Grinding teeth Snoring
 - Other: _____

We'd like to know more about you so we can better server you!

- 8. Do you prefer appointments in the (Check all that apply):
 - Early morning Early afternoon No preference
 - Late morning Late afternoon Other: _____
- 9. Do you have any special dates or upcoming events you'd like us to remember? (weddings, graduations, etc.)

- 10. What type(s) of music do you enjoy? (Check all that apply):
 - Easy Listening Classical Rock Hip-Hop/Rap
 - Jazz Country R&B Other: _____
- 11. What are your favorite hobbies or activities

- 12. Do you have children and grandchildren? If so, please list their names and ages.

- 13. Is there anything else that you want our office to know about you that will help us to serve you better?
