

Welcome to Our Office

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Patient Information (CONFIDENTIAL):

"State of the Art Dentistry with Hometown Comfort and Caring"

Name: _____ DOB: _____ Today's Date: _____

Home Phone: _____ CellPhone: _____

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

(Check Appropriate Box) Sex: Male Female Marital Status: Minor Single Married Divorced Widowed

SSN: _____ Who May We Thank for Referring You? _____

Driver's License # _____ Email Address: _____

Employer: _____ City: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

(Please Initial Below) **Dental Compensation Plan/Insurance:** Yes No Yearly Allowance _____ Patient Does Not Know

I understand that dental plans do not cover 100% of dental treatment. I am aware that the estimated portion that my insurance will pay is a "good faith" estimate. I understand that insurance coverage is based on the plan my employer/my spouse's employer/my parent's employer has purchased from the insurance company. It is my responsibility to know how my plan pays and its limitations. *(Please Circle One)*

Policy Holder's Name: _____ SSN: _____ DOB: _____

Patient Medical History:

Physician: _____ City: _____ Date of Last Exam: _____

- | | Yes | No | | Yes | No |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Are you under medical treatment now? | <input type="checkbox"/> | <input type="checkbox"/> | 7. Are you allergic to or have any reactions to the following: | | |
| | | | Local anesthetics (eg. novocaine)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you taking any medications including OTC Medications, Vitamins and Suppliments? | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin or other Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | | | Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | | | Other: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | | | | | |
| _____ | | | 8. Are you latex sensitive? | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | | | 9. Do you have food or dye allergies? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you on a daily aspirin (or other blood thinners) regimen? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Women Only | | |
| 4. Do you use alcohol more than 3 times a week? | <input type="checkbox"/> | <input type="checkbox"/> | a) Are you pregnant or think you may be pregnant | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use tobacco? | <input type="checkbox"/> | <input type="checkbox"/> | b) Are you nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you used recreational drugs in the past year? | <input type="checkbox"/> | <input type="checkbox"/> | c) Birth control: Do you use pills, patches or shots? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | d) N/A | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 11. Have you had joint replacement or implant surgery
If yes, please describe. | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | _____ | | |
| | | | 12. Have you ever had spinal fusion or any other surgery that
required pins, plates or screws? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Describe _____ | | |
| | | | _____ | | |

For 11 and 12- Month and Year of Surgery: _____

Name of Orthopaedic Surgeon: _____

Patient Medical History (continued)

13. Do you have, or have you had any of the following:

		Yes	No			Yes	No			Yes	No
Tuberculosis/Positive TB Test.....	<input type="checkbox"/>	<input type="checkbox"/>		Artificial Heart Valves.....	<input type="checkbox"/>	<input type="checkbox"/>		MRSA.....	<input type="checkbox"/>	<input type="checkbox"/>	
Persistent Cough, Night Sweats, Fever	<input type="checkbox"/>	<input type="checkbox"/>		Heart Trouble/Surgery/Pacemaker..	<input type="checkbox"/>	<input type="checkbox"/>		Crohn's/Ulcerative Colitis.....	<input type="checkbox"/>	<input type="checkbox"/>	
Mitral Valve Prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>		Heart Attack/Stents.....	<input type="checkbox"/>	<input type="checkbox"/>		Anorexia/Bulimia.....	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>		Angina/Chest Pains.....	<input type="checkbox"/>	<input type="checkbox"/>		Hearing Difficulty.....	<input type="checkbox"/>	<input type="checkbox"/>	
Fainting/Seizures.....	<input type="checkbox"/>	<input type="checkbox"/>		Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>		High/Low Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	
Vertigo/Dizzy Spells.....	<input type="checkbox"/>	<input type="checkbox"/>		Frequently Tired/Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>		Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding Disorder/Blood Thinners.....	<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/Radiation Treatment.....	<input type="checkbox"/>	<input type="checkbox"/>		Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	
Leukemia.....	<input type="checkbox"/>	<input type="checkbox"/>		Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>		Asthma/Resp. Problems.....	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>		Hepatitis (type__)Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>		(Frequency of attacks)_____			
Kidney Disease/Dialysis.....	<input type="checkbox"/>	<input type="checkbox"/>		Sexually Transmitted Disease.....	<input type="checkbox"/>	<input type="checkbox"/>		Allergies/Sinus Problems.....	<input type="checkbox"/>	<input type="checkbox"/>	
AIDS/HIV Infection.....	<input type="checkbox"/>	<input type="checkbox"/>		Stomach Troubles/Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>		Psychiatric Treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Problem.....	<input type="checkbox"/>	<input type="checkbox"/>		C-Diff Infection.....	<input type="checkbox"/>	<input type="checkbox"/>		Osteoporosis.....	<input type="checkbox"/>	<input type="checkbox"/>	
								Other.....	<input type="checkbox"/>	<input type="checkbox"/>	

Patient Dental History:

What problem or concern about your dental health brought you to our office today? _____

		Yes	No			Yes	No
1. Do your gums bleed while brushing or flossing?	<input type="checkbox"/> Sometimes	<input type="checkbox"/>	<input type="checkbox"/>	14. Have you had difficult extractions in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever noticed any gum swelling around your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you had prolonged bleeding following extractions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Does food catch between your teeth?	<input type="checkbox"/> Sometimes	<input type="checkbox"/>	<input type="checkbox"/>	16. Have you had any orthodontic work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you ever avoid any part of your mouth while brushing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17. Do you feel you will eventually wear dentures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If so, what area(s)? _____				18. Have you been diagnosed with/treated for Periodontal disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Are your teeth sensitive to hot or cold liquids or foods?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19. Does your family have a history of tooth loss due to gum disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Are your teeth sensitive to sweet or sour liquids or foods?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	20. What fears do you have about visiting the dentist?			
7. Do you currently have pain in any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
8. Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21. When was your last dental appointment? _____			
9. Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What was it for? _____			
10. Have you experienced any of the following problems in your jaw?				22. What x-rays were taken at that visit? _____			
a) Clicking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	23. When was your last preventative care/cleaning appointment? _____			
b) Pain (joint, ear, side of face)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	24. Why did you leaving your last dentist?			
c) Difficulty in opening or closing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
d) Difficulty in chewing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	25. Is there anything about your teeth you have always wanted to change? (explain) _____			
11. Have you have any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
12. Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
13. Does it seem you always have something to be treated or repaired when you visit the dentist?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

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 agree to be responsible for payment of all services rendered on my behalf or my dependents and understand that should my account go into default, I am responsible for collection fees up to 35% plus legal fees. Payment for services is expected at the time of service. The dental office will text me at the number I have provided to confirm my dental appointments in advance. It is my responsibility to keep the office up to date on current contact information. The dental office reserves the right to remove unconfirmed appointments from the schedule. 24 hours notice is required to cancel or change appointments. Failed appointments may result in a charge or the loss of the privilege to pre-schedule appointments.

X _____ X _____
Signature of patient or of parent/legal guardian if minor (Date) Review/Signature (Date)

X _____ X _____
Review/Signature (Date) Review/Signature (Date)

X _____ X _____
Review/Signature (Date) Review/Signature (Date)

X _____ X _____
Review/Signature (Date) Review/Signature (Date)

X _____ X _____
Review/Signature (Date) Review/Signature (Date)