WELCOME

PATIENT INFORMATION

Date

SS/HIC/Patient ID #

Patient Name

Address

City

State Zip

E-mail

Sex ☐ Male ☐ Female Age

Birthdate

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ___ years

Occupation

Patient Employer/School

Employer/School Address

Employer/School Phone ( )

Spouse's Name

Birthdate

SS#

Spouse's Employer

Whom may we thank for referring you?

DENTAL INSURANCE

Who's responsible for this account?

Relationship to Patient

Insurance Co.

Group #

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name

Birthdate SS#

Relationship to Patient

Insurance Co.

Group #

ASSIGNMENT AND RELEASE

I certified that I, and/or my dependent(s), have insurance coverage with

Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date Relationship to Patient

PHONE NUMBERS

Home ( ) Work ( ) Ext. Cell ( )

Spouse's Work ( ) Best time and place to reach you

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name Relationship

Home Phone ( ) Work Phone ( )

DENTAL HISTORY

Reason for today's visit

Former Dentist

City/State

Date of last dental visit

Date of last dental X-rays

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in mouth	☐ Yes	☐ No

How often do you floss? _____

How often do you brush? _____

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). □ Yes □ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AID/HIV	□ Yes	□ No	Epilepsy	□ Yes	□ No	Respiratory Disease	□ Yes	□ No
Anemia	□ Yes	□ No	Fainting or dizziness	□ Yes	□ No	Rheumatic Fever	□ Yes	□ No
Arthritis, Rheumatism	□ Yes	□ No	Glaucoma	□ Yes	□ No	Scarlet Fever	□ Yes	□ No
Artificial Heart Valve	□ Yes	□ No	Headaches	□ Yes	□ No	Shortness of Breath	□ Yes	□ No
Artificial Joints	□ Yes	□ No	Heart Murmur	□ Yes	□ No	Sinus Trouble	□ Yes	□ No
Asthma	□ Yes	□ No	Heart Problems	□ Yes	□ No	Skin Rash	□ Yes	□ No
Back Problems	□ Yes	□ No	Hepatitis Type _____	□ Yes	□ No	Special Diet	□ Yes	□ No
Bleeding abnormally, with extractions or surgery	□ Yes	□ No	Herpes	□ Yes	□ No	Stroke	□ Yes	□ No
			High Blood Pressure	□ Yes	□ No	Swollen Feet or Ankles	□ Yes	□ No
Blood Disease	□ Yes	□ No	Jaundice	□ Yes	□ No	Swollen Neck Glands	□ Yes	□ No
Cancer	□ Yes	□ No	Jaw Pain	□ Yes	□ No	Thyroid Problems	□ Yes	□ No
Chemical Dependency	□ Yes	□ No	Kidney Disease	□ Yes	□ No	Tonsillitis	□ Yes	□ No
Chemotherapy	□ Yes	□ No	Liver Disease	□ Yes	□ No	Tuberculosis	□ Yes	□ No
Circulatory Problems	□ Yes	□ No	Low Blood pressure	□ Yes	□ No	Tumor or growth on head or neck	□ Yes	□ No
Congenital Heart Lesions	□ Yes	□ No	Mitral Valve Prolapse	□ Yes	□ No			
Cortisone Treatments	□ Yes	□ No	Nervous Problems	□ Yes	□ No	Ulcer	□ Yes	□ No
Cough, persistent or bloody	□ Yes	□ No	Pacemaker	□ Yes	□ No	Venereal Disease	□ Yes	□ No
Diabetes	□ Yes	□ No	Psychiatric care	□ Yes	□ No	Weight Loss, unexplained	□ Yes	□ No
Emphysema	□ Yes	□ No	Radiation Treatment	□ Yes	□ No			

Do you wear contact lenses? □ Yes □ No

Women:

Are you pregnant? □ Yes □ No Due Date _____ Are you nursing □ Yes □ No

Taking birth control pills? □ Yes □ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

Pharmacy Name _____

Phone ( ) _____

ALLERGIES

□ Aspirin
□ Barbiturates (Sleeping pills)
□ Codeine
□ Iodine
□ Latex
□ Local Anesthetic
□ Penicillin
□ Sulfa
□ Other _____

UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? □ Yes □ No

For what conditions? _____

Are you taking any new medications? □ Yes □ No If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? □ Yes □ No

For what conditions? _____

Are you taking any new medications? □ Yes □ No If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____