WELCOME TO OUR OFFICE

Date_____

Name_____
Last First MI Title

I Prefer To Be Called _____ □ Male □ Female

Birthdate_____ SSN_____

Address _____ City _____ State ___ Zip_____

Home Phone _____ Work Phone_____

Cell Phone _____ E-Mail _____

Best Way To Reach You?_____ Best Time?_____

Marital Status □ Single □ Married □ Divorced □ Widowed

Employer_____ Occupation_____

Person Responsible For Account_____

Address_____ City_____State___ Zip_____

Phone_____ Relationship_____

Emergency Contact_____ Phone_____

Relationship_____

Whom May We Thank For Referring You?_____

Other Family Members Seen By Us?_____

Previous/Present Dentist?_____ Last Visit Date?_____

DENTAL HISTORY

How may we help you today?_____

Your current dental health is □ Good □ Fair □ Poor

Do your require antibiotics before dental treatment? □ Yes □ No

Are you currently in pain? □ Yes □ No

When was your last dental cleaning?_____

Have you ever had gum treatment? □ Yes □ No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) □ Yes □ No

Do you like your smile? □ Yes □ No

Is there anything you would like to change about your smile? □ Yes □ No
If you answered yes, please explain_____

Are you happy with the color of your teeth? □ Yes □ No

Do your gums bleed? □ Yes □ No

How many times do you: Floss/week? _____ Brush/day?_____

Are your teeth sensitive to hot, cold, or anything else? □ Yes □ No

Have you lost any teeth? □ Yes □ No If yes, why?_____

Have you ever had a problem with any previous dental experience or dental work? □ Yes □ No

How can we accommodate you better during your dental visit?_____

Do you have fixed bridgework? □ Yes □ No Removable partial or full denture? □ Yes □ No

We offer a wide variety of services to enhance and keep your smile healthy and beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

WHITENING	CROWNS	IMPLANT CROWNS
NIGHT/SPORT GUARDS	FIXED BRIDGES	IMPLANT DENTURES
SMILE MAKEOVERS	BONDING	PARTIALS/DENTURES
ORAL APNEA APPLIANCE	SEALANTS	ROOT CANALS

DENTAL INSURANCE

PRIMARY

Subscriber Name_____ DOB_____ Relationship to Patient_____

Subscriber SSN or ID_____ Subscriber Employer_____

Insurance Company Name_____

Insurance Company Address_____

Insurance Company Phone_____ Group Number_____

SECONDARY

Subscriber Name_____ DOB_____Relationship to Patient_____

Subscriber SSN or ID_____ Subscriber Employer_____

Insurance Company Name_____

Insurance Company Address_____

Insurance Company Phone_____ Group Number_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependents) have insurance coverage and assign this office all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.
I understand that I am financially responsible for all charges whether or not paid by insurance. I further understand that any delinquent balances may be turned over to a collection agency for further collection efforts and any fee occurring from the use of a collection agency, attorney, or any other outside service to assist in the collection of any delinquent balances shall be borne by me alone. These fees will be added to my already delinquent balance. This includes but is not limited to collection fees, attorney, court cost, etc.

Responsible Party Signature_____

Relationship_____ Date_____

Consent: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature_____

MEDICAL HISTORY

Do you have a personal physician? □ Yes □ No
Physician's Name _____ Phone _____
Date of Last Visit _____ Your Current health is □ Good □ Fair □ Poor
Do you use tobacco in any form? □ Yes □ No
Have you had any joint replacements, metal rods, pins, or implants placed? □ Yes □ No
Are you taking any medications? □ Yes □ No
Please list each one _____
Have you ever taken Fosamax, or any other bisphosphonate? □ Yes □ No
Have you ever taken Phen-Fen? □ Yes □ No
Have you ever been diagnosed with sleep apnea? □ Yes □ No
Do you use a CPAP or oral appliance?

Have you ever had any of the following diseases or medial problems

Y N Abnormal Bleeding
Y N Alcohol/Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Heart Valve
Y N Asthma
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Facial Surgery
Y N Fainting Spells
Y N Fever Blisters
Y N Frequent Headaches
Y N HIV/AIDS
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis A B C (circle one)
Y N High Blood Pressure
Y N **Joint Replacement**
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Therapy
Y N Rheumatic Fever
Y N Seizures
Y N Sexually Transmitted Disease
Y N Shingles
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers

ALLERGIES
Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Nickel
Y N Penicillin
Y N Tetracycline
Y N Sulfa

FOR WOMEN
Y N Are you taking birth control pills?
Y N Are you pregnant? If so, # of weeks ___
Y N Are you nursing?

Nearest relative not living with you:
Name_____ Relationship_____
Address_____Phone_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature_____ Date_____