Welcome!

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

Patient Information (Confidential)

Today's Date: _____

Legal Name: _____ Preferred Name: _____

DOB: _____ SSN: ___-___-___ DL#: _____ State: _____

Address: _____ City:_____

State: _____ Zip: _____ Email: _____

Home Phone: _____ Cell Phone: _____

Preferred method of communication (check all that apply): ☐ cell ☐ home ☐ email

Okay to leave message containing PHI on voicemail?: ☐ yes ☐ no

If patient is a minor, Name of Parents and/or Legal Guardians: _____

If patient is a full-time college student, name of college: _____

If patient employed, Name of employer: _____

Work Phone: _____ Work Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone: _____

Whom may we thank for referring you: _____

Responsible Party (Who is responsible for the bill?)

***Only fill this out if this person is not the patient or if the patient is a minor.

Name: _____ Relation to patient: _____

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

DOB: _____ SSN: ___-___-___ DL#: _____ State: _____

Employer: _____ Work Phone: _____

Is this person a current patient of our office? ☐ yes ☐ no

Dental Insurance/Benefits (Please give your card to the receptionist for copying)

Insurance company: _____

Group #: _____ ID#: _____ Payor ID#: _____

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

Name of Primary Subscriber: _____ Relation to pt: _____

****If the primary subscriber is NOT the patient or the Responsible Party above, please complete the following:*

Subscriber's Personal Information (confidential)

DOB: _____ SSN: _____-_____-_____

Employer: _____ Work Phone: _____

Work Address: _____

City: _____ State: _____ Zip: _____

If you have additional DENTAL BENEFITS (i.e. "dual coverage"), Please complete the following:

Insurance company: _____

Group #: _____ ID#: _____ Payor ID#: _____

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

Name of Primary Subscriber: _____ Relation to pt: _____

SUB. DOB: _____ SUB. SSN: _____-_____-_____

SUB. Employer: _____ Work Phone: _____

Work Address: _____

City: _____ State: _____ Zip: _____

Patient Medical History

Patient name: _____ Date: _____

Physician/MD: _____ Phone: _____

Date of Last Medical Exam: _____

Gender assigned at birth: _____ Gender Identity: _____

Preferred Pronouns: _____

	Y	N
1. Are you under medical treatment now?	☐	☐
2. Have you had a full or partial joint replacement?	☐	☐
• Does your orthopedist require antibiotics before dental treatment?	☐	☐
3. Do you have a history of infective endocarditis?	☐	☐
4. Do you have an artificial heart valve?	☐	☐
5. Are you currently taking any medications?	☐	☐
• *Please list below or provide comprehensive list to receptionist to copy.*		
6. Do you currently or have you ever used tobacco?	☐	☐

☐ Smoking ☐ Smokeless/Chewing ☐ Vape

How long did you use? _____ How long since quitting? _____

	Y	N
7. Are you or have you ever taken Fen-Phen or Redux?	☐	☐
8. Have you ever taken or are you currently treated for osteoporosis/osteopenia with bisphosphonates (Fosamax, Actonel, Boniva, etc.) or Prolia?	☐	☐
9. Are you currently taking any "blood thinner" medication?	☐	☐

10. Allergies:

	Y	N
1. Penicillin/Amoxicillin	☐	☐
2. Sulfa Drugs	☐	☐
3. Latex	☐	☐
4. Local Anesthetics	☐	☐
5. Aspirin	☐	☐
6. Codeine	☐	☐
7. Other	☐	☐

_____

_____

11. Are you currently experiencing or have you had prior experience with any of the following?

Y	N		Y	N	
☐	☐	Head & Neck Cancer	☐	☐	Sleep Apnea
☐	☐	Head & Neck Radiation Therapy	☐	☐	Snoring
☐	☐	Leukemia	☐	☐	Difficulties with sleep
☐	☐	Other Cancers	☐	☐	Respiratory Problems
☐	☐	Cancer Treatment	☐	☐	Asthma
☐	☐	Osteoporosis/Paget's Disease	☐	☐	Emphysema

Y	N		Y	N	
☐	☐	Stomach Troubles/Ulcers	☐	☐	Joint Replacement
☐	☐	GERD/Acid Reflux	☐	☐	Mental Health/Depression
☐	☐	Recent Weight Gain or Loss	☐	☐	Anorexia/Bulimia
☐	☐	Diabetes	☐	☐	Fainting/Seizures
☐	☐	Angina	☐	☐	Epilepsy/Convulsions
☐	☐	Heart attack	☐	☐	Kidney Disease
☐	☐	Cardiac Arrhythmia	☐	☐	Hepatitis
☐	☐	Cardiac Pacemaker	☐	☐	Liver Disease
☐	☐	Infective Endocarditis	☐	☐	Glaucoma
☐	☐	Rheumatic Fever	☐	☐	Tuberculosis
☐	☐	High Blood Pressure	☐	☐	Arthritis
☐	☐	Low Blood Pressure	☐	☐	HIV/AIDS
☐	☐	Stroke			

Please list any other serious medical conditions (past or present) not listed: _____

_____

_____

Please provide a comprehensive list of medications or write them here :_____

_____

Women only:

	Y	N
1. Are you pregnant or is there a possibility you could be pregnant? _____	☐	☐
2. Are you nursing? _____	☐	☐
3. Are you taking birth control pills? _____	☐	☐

Patient Dental History

Name of prior dentist: _____

Prior dentist phone number: _____ email: _____

Date of your last dental appointment: _____ Reason: _____

Reason for dental visit today: _____

_____

	Y	N
1. Are you currently experiencing dental pain?	☐	☐
2. Are your teeth typically sensitive to hot or cold liquids or foods?	☐	☐
3. Are your teeth sensitive to sweet/sour liquids or foods?	☐	☐
4. Do you ever have tooth pain when chewing?	☐	☐
5. Have you noticed any lumps/bumps or sores/ulcerations in your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Do you have frequent headaches?	☐	☐
8. Do you clench or grind your teeth?	☐	☐
9. Do you bite your lips or cheeks frequently?	☐	☐
10. Have you ever had orthodontic treatment?	☐	☐
11. Do you use a mouth appliance/splint?	☐	☐
For what reason: _____		
12. Have you ever had prolonged bleeding following a dental extraction?	☐	☐
13. Have you ever been given instruction on proper brushing and flossing?	☐	☐
14. Do your gums bleed while brushing or flossing?	☐	☐
15. Are you happy with your smile?	☐	☐

16. Have you ever experienced any of the following with your TMJ (jaw joint):

Clicking: ☐ Yes ☐ No ☐ Left ☐ Right

Locking: ☐ Yes ☐ No ☐ When Open ☐ When Closed

Pain: ☐ Yes ☐ No ☐ Left ☐ Right

Difficulty with chewing: ☐ Yes ☐ No

Authorization and Release

I certify that I have read and I have understood the above information. 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 records of any treatment or examination rendered to me or my dependent (if patient is a minor) during the period of such dental care, to their party payer and/or health practitioners.

I understand that knowing the details of my dental benefits plan ("insurance"), including eligibility, limitations and benefits, is my responsibility. I understand that my carrier may pay less that the actual bill for services.

I authorize and request my dental insurance company to pay benefits directly to the dentist as applicable.

I understand that I am financially responsible for payment of all services, whether or not they are paid by my dental benefits plan, for me or my dependent (if patient is a minor).

_____ _____

Date Signature of Patient or parent of minor

_____

Printed name of Patient or parent of minor