PATIENT INFORMATION

PATIENT'S NAME Last ______ First ______ Middle Initial ______ SEX: M F BIRTHDATE ______ AGE ______

Soc. Sec. # ______ If Patient is a Minor, give Parent's or Guardian's Name ______ TODAY'S DATE ______

Who May We Thank for Referring You to our Office? ______ Reason for this Visit ______

RESPONSIBLE PARTY INFORMATION

NAME Last ______ First ______ Middle Initial ______ MARITAL STATUS ______

RESIDENCE Street ______ Apt. # ______ City ______ State ______ Zip ______

MAILING ADDRESS Street ______ Apt. # ______ City ______ State ______ Zip ______

HOW LONG AT THIS ADDRESS ______ HOME PHONE ______ CELL PHONE ______

WORK PHONE ______ E-MAIL ______

PREVIOUS ADDRESS (if less than 3 yrs.) Street ______ City ______ State ______ Zip ______ How Long ______

SOCIAL SECURITY # ______ BIRTHDATE ______ DRIVER'S LICENSE # ______ RELATION TO PATIENT ______

EMPLOYER ______ OCCUPATION ______ NO. YEARS EMPLOYED ______

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name ______

Insurance Co. ______ E-MAIL ______

Insurance Co. Address ______

Insured's Employer ______

Insured's Soc. Sec. # ______ Group # ______ Local # ______

If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name ______

Insurance Co. ______ E-MAIL ______

Insurance Co. Address ______

Insured's Employer ______

Insured's Soc. Sec. # ______ Group # ______ Local # ______

DENTAL HISTORY	YES	NO
HOW LONG SINCE you have seen a dentist?		
Last COMPLETE Dental Exam, Date:		
Last FULL MOUTH X-RAYS, DATE: (16 Small Films or Panoramic)		
Are you having PROBLEMS now?	❑	❑
WHAT?		
Is your present dental health POOR?	❑	❑
Do you wear DENTURES? (Partials or Full)	❑	❑
Are you UNHAPPY with your dentures?	❑	❑
Would you like to know more about PERMANENT REPLACEMENTS?	❑	❑
Are you APPREHENSIVE about dental treatment?	❑	❑
Have you had any PERIODONTAL (GUM) treatments?	❑	❑
Do your gums BLEED, or feel TENDER or IRRITATED?	❑	❑
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	❑	❑
Are you UNHAPPY with the APPEARANCE of your teeth?	❑	❑
Are you aware of GRINDING or CLENCHING your teeth?	❑	❑
Do you have HEADACHES, EARACHES, or NECK PAINS?	❑	❑
Have you worn BRACES on your teeth (ORTHODONTICS)	❑	❑
Do you have DISCOLORED teeth that bother you?	❑	❑
Would you like your smile to LOOK BETTER or DIFFERENT?	❑	❑
Do you REGULARLY use DENTAL FLOSS?	❑	❑
Name of Previous Dentist:		
City: State:		
How do you feel about your teeth?		
Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	❑	❑

Is there any other Medical or Dental information that you feel I should know about?

FAMILY PHYSICIAN ______ PHONE ______

E-MAIL ______

MEDICAL HISTORY	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	❑	❑
Are you under a PHYSICIAN'S CARE now?	❑	❑
For what?		
What MEDICATIONS are you currently taking?		
Have you ever taken Fen-Phen/Redux?	❑	❑
Are you PREGNANT?	❑	❑
Do you use cigars/cigarettes, pipe or chewing tobacco? (circle)	❑	❑

PLEASE ✔ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

	YES	NO		YES	NO		YES	NO
AIDS/HIV Pos.	❑	❑	Fainting	❑	❑	Psychiatric care	❑	❑
Anaphylaxis	❑	❑	Food allergies	❑	❑	Rapid weight gain/loss	❑	❑
Anemia	❑	❑	Glaucoma	❑	❑	Radiation treatment	❑	❑
Arthritis (Rheumatism)	❑	❑	Headaches	❑	❑	Respiratory disease	❑	❑
Artificial heart valves	❑	❑	Heart murmur	❑	❑	Rheumatic/scarlet fever	❑	❑
Artificial joints	❑	❑	Heart problems (please describe)	❑	❑	Shingles	❑	❑
Asthma	❑	❑	______			Shortness of breath	❑	❑
Atopic (Allergy Prone)	❑	❑	Hemophilia (Abnormal bleeding)	❑	❑	Skin rash	❑	❑
Back problems	❑	❑	Herpes	❑	❑	Spina Bifida	❑	❑
Blood disease	❑	❑	Hepatitis	❑	❑	Stroke	❑	❑
Cancer	❑	❑	High blood pressure	❑	❑	Surgical implant	❑	❑
Chemical dependency	❑	❑	Jaw pain	❑	❑	Swelling of feet or ankles	❑	❑
Chemotheropy	❑	❑	Kidney disease or malfunction	❑	❑	Thyroid disease or malfunction	❑	❑
Circulatory problems	❑	❑	Liver disease	❑	❑	Tobacco habit	❑	❑
Cortisone treatments	❑	❑	Material allergies (latex, wool, metal, chemicals)	❑	❑	Tonsillitis	❑	❑
Cough (persistent)	❑	❑				Tuberculosis	❑	❑
Cough up blood	❑	❑	Mitral valve prolapse	❑	❑	Ulcer/Colitis	❑	❑
Diabetes	❑	❑	Nervous problems	❑	❑	Venereal disease	❑	❑

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin, Local Anesthetic, Erythromycin, Latex (balloons, gloves, etc.), Nitrous Oxide, Codeine, Penicillin

Are you aware of being allergic to any other medications or substances?

If yes, please list: ______

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ______ Date ______

Payment is due in full at time of treatment unless prior arrangements have been approved.