W E L C O M E

In order to ensure your maximum oral health and allow us to prescribe the proper medications, it is very important that we know all medical and dental information about you. Please check every box on the front and back of this form, even if the answer is "N/A" (no applicable). This information will be kept in the strictest confidence.

You also should know that changes in other parts of your body may affect the oral cavity and what dental treatments can be done, even if they seem unconnected. Cardiac (heart) problems, artificial joints and diabetes are just some examples.

Will you please inform the dentist or the staff at the beginning of each new office visit if your medical or dental conditions have changed since we last saw you? Yes ❑ No ❑ Thank you.

1 Patient Information: Date: __________

(Please Print)

Name ______________________________

Address ____________________ Apt.# ____________

City ____________ State ____________ Zip ________

Date of Birth __________ Social Security ______________

Gender____ Drivers Lic. # & St. Issued ______________

Cell Phone ____________ Home Phone ____________

Place of Employment/School ______________________

Work/School Phone Number ________________ Ext ______

Email ______________________________

Marital Status ______________________________

IN CASE OF EMERGENCY:

Contact ______________________________

Relationship ______________________________

Cell Phone ____________ Home/Work Phone ____________

Whom may we thank for referring you? ______________

2 Dental Insurance:

Primary Policy Holder's Name ______________________

Date of Birth __________ Social Security ______________

Insurance Company's Name ______________________

Insurance Company's Phone Number ______________________

Member's ID # ____________ Group # ______________

Employer ______________________________

Do you have a Secondary Dental Policy? Yes ❑ No ❑

Medical Insurance:

Subscriber/Policy Holder's Name ______________________

Date of Birth __________ Employer/ Group Name ______________

Insurance Company's Name ______________________

Insurance Company's Address ______________________

Insurance Company's Phone Number ______________________

Member's ID # ____________ Group # ______________

3 RESPONSIBLE PARTY INFORMATION:

If patient is a minor, Parent / Guardian Information:

Name ______________________________

Address ____________________ Apt.# ____________

City ____________ State ____________ Zip ________

Date of Birth __________ Social Security ______________

Gender____ Drivers Lic. # & St. Issued ______________

Cell Phone ____________ Home Phone ____________

Place of Employment/School ______________________

Work/School Phone Number ________________ Ext ______

Email ______________________________

4 Assignment and Release:

I certify that I (or my dependent) have insurance coverage as indicated and assign directly to this office all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid or not paid by insurance. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

All balances are due in full within 60 days whether insurance has paid or not. At this point a $5^{00} rebilling charge will be added to your account each month. If account goes to collection, collection costs will be added.

Responsible Party ____________________ Date __________

Print Name ______________________________

Relationship to Minor (if applicable) ______________________

See Back Side

W E L C O M E

W E L C O M E

1 Dental History

Patient Name: ______________________
Reason for today's visit: ______________________
Former Dentist: ______________________
Date of last visit: ______________________
Date of last x-rays: ______________________
Why did you leave: ______________________

Mark yes or no to indicate if you presently have or previously had any of the following:

Are your gums swollen or tender	❑ Yes	❑ No
Are your teeth sensitive	❑ Yes	❑ No
Are you a mouth breather	❑ Yes	❑ No
Bite your lips or cheeks regularly	❑ Yes	❑ No
Do your gums bleed easy	❑ Yes	❑ No
Do you chew on one side of mouth	❑ Yes	❑ No
Do you have constant bad breath	❑ Yes	❑ No
Do you wear dentures/partials	❑ Yes	❑ No
Do you have difficulty chewing food	❑ Yes	❑ No
Do you avoid brushing/flossing any part of your mouth due to pain or bleeding	❑ Yes	❑ No
Do you require antibiotics before any dental treatment	❑ Yes	❑ No
Does jaw pain/discomfort affect any partof your day	❑ Yes	❑ No
Do you take any kind of medications for the pain/discomfort	❑ Yes	❑ No
Do you have dry mouth or thirsty most of the time	❑ Yes	❑ No
Does food collect between teeth	❑ Yes	❑ No
Do you gag easy	❑ Yes	❑ No
Do you grind your teeth	❑ Yes	❑ No
Have you or do you have slow healing sores in your mouth	❑ Yes	❑ No
Have you been diagnosed with TMJ or TMD	❑ Yes	❑ No
Have you had any kind of injury to your jaw	❑ Yes	❑ No
Jaw pain or tiredness	❑ Yes	❑ No
Orthodontic treatment	❑ Yes	❑ No
Pain around ear side, of face, jaw area	❑ Yes	❑ No
Back or neck pain	❑ Yes	❑ No
Periodontal (gum) treatment	❑ Yes	❑ No
Sensitivity to hot or cold	❑ Yes	❑ No
Frequent headaches	❑ Yes	❑ No
Difficulty in opening, closing your mouth or does it get stuck open or closed	❑ Yes	❑ No
Do you have clicking or popping of the jaw	❑ Yes	❑ No
Are you currently in pain	❑ Yes	❑ No

How often do you floss? ______________________
How often do you brush? ______________________

Have you ever had a bad experience in a dental office or are you nervous about having treatment? ❑ Yes ❑ No

Yes, please describe ______________________

____

Is there anything else about having dental treatment that you would like us to know? ______________________

____

2 Medical History

Are you currently under the care of a physician ❑ Yes ❑ No
If yes, please explain: ______________________
Physician's name: ______________________
Physician's phone number ______________________
Are you taking any prescription/over-the-counter drugs ❑ Yes ❑ No
If yes, please list each one: ______________________

____

Do you smoke or use any form of tobacco ❑ Yes ❑ No

Are you allergic to any of the following?
Aspirin / Codeine (or any other pain medications) / Dental Anesthetics / Latex / Metals / Penicillin / Sulfa / Tetracycline
Please list any other drugs / materials not listed that you are allergic to

____

Do you have or have you ever had any of the following diseases or medical problems?

Abnormal bleeding / Hemophilia / Bruise Easily	❑ Yes	❑ No
Alcohol / Drug Abuse	❑ Yes	❑ No
Alzheimer's disease	❑ Yes	❑ No
Anemia	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No
Have you been or are you currently being treated for Osteoporosis?	❑ Yes	❑ No
Artificial bones / Joint replacements / Valves	❑ Yes	❑ No
Asthma	❑ Yes	❑ No
Blood transfusion / Blood diseases / Leukemia	❑ Yes	❑ No
Bone Density Drugs	❑ Yes	❑ No
Cancer / Chemotherapy	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
Difficulty breathing / Shortness of breath / Emphysema	❑ Yes	❑ No
Epilepsy / Fainting spells	❑ Yes	❑ No
Hay fever / Seasonal allergies / Sinus problems	❑ Yes	❑ No
Heart problems / Pacemaker / Chest pains / Stroke	❑ Yes	❑ No
Heart murmur / Heart valve problem / M V P	❑ Yes	❑ No
Hepatitis ❑ Yes ❑ No (if yes, which one) ❑ A ❑ B ❑ C		
High blood pressure / Blood pressure problems	❑ Yes	❑ No
HIV/AIDS	❑ Yes	❑ No
Venereal disease	❑ Yes	❑ No
Herpes	❑ Yes	❑ No
Fever blisters	❑ Yes	❑ No
Kidney / Liver disease	❑ Yes	❑ No
Lung disease / Lung transplant	❑ Yes	❑ No
Psychiatric / Psychological care	❑ Yes	❑ No
Radiation treatment	❑ Yes	❑ No
Rheumatic fever / Scarlet fever	❑ Yes	❑ No
Sleep apnea	❑ Yes	❑ No
Thyroid problems	❑ Yes	❑ No
Tuberculosis (TB)	❑ Yes	❑ No
Tumors or Growths / Skin rashes	❑ Yes	❑ No
Do you have or have you ever had any disease, condition or problem not listed?	❑ Yes	❑ No

If yes, please explain ______________________

____

For Women:

Are you taking birth control pills	❑ Yes	❑ No
Are you pregnant or think you might be pregnant	❑ Yes	❑ No
Are you nursing	❑ Yes	❑ No

3

CERTIFICATION: I certify that the answers given are correct to the best of my knowledge.

Date ______________________

Signature ______________________ Print Name ______________________