DENTAL INFORMATION

Reason for visit today: O Exam O Emergency O Consultation
Are you in pain today? O No O Yes If Yes, for how long and where? _____

Please indicate if you have any of the following problems:
O Discomfort, popping, or clicking in the jaw O Lost or broken filling O Stained teeth O Teeth grinding
O Red, swollen, or bleeding gums O Locking jaw O Ringing in ears O Bad breath
O Sensitive tooth, teeth, or gums O Broken or chipped tooth O Blisters/sores in or around the mouth
O Other: _____

Do you require premedication before dental treatment? O No O Yes O Unsure

Previous dentist: _____ **Phone number**: (___) ___-____
Date of last exam: ___/___/_____ **Date of last x-rays**: ___/___/_____

Times per day you brush? _____ **Times per week you floss?** _____ **Brand/Type of toothbrush used?** _____
What type of tooth brush do you use? O Soft O Medium O Hard

How would you rate your smile? 1 2 3 4 5 6 7 8 9 10
What would you like to change about your smile? _____

MEDICAL HISTORY

Are you currently under a physician's care? O No O Yes, **MD name:** _____ **MD phone #** _____
Have you ever been hospitalized or had a major operation? O No O Yes _____
Have you ever had a serious head or neck injury? O No O Yes _____
List all current medications/vitamins:_____
_____

Have you ever taken any of the following medications? O Phen-Fen, Redux or other diet pills / O Fosamax, Boniva, Actonel or any other bisphophonate
Are you on a special diet: O No O Yes If yes, what kind? _____
Do you use tobacco? O No O Yes, Form:_____How much? _____ How long? _____
Do you use controlled substances? O No O Yes
Are you allergic to any of the following: O Aspirin O Penicillin O Codeine O Local anesthetics O Acrylic O Metal O Latex O Sulfa Drugs
Other(s) _____

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

Y / N AIDS/HIV Positive	**Y / N** Cortisone Medicine	**Y / N** Hemophilia	**Y / N** Radiation Treatments
Y / N Alzheimer's Disease	**Y / N** Diabetes	**Y / N** Hepatitis A	**Y / N** Recent Weight Loss
Y / N Anaphylaxis	**Y / N** Drug Addiction	**Y / N** Hepatitis B or C	**Y / N** Renal Dialysis
Y / N Anemia	**Y / N** Easily Winded	**Y / N** Herpes	**Y / N** Rheumatic Fever
Y / N Angina	**Y / N** Emphysema	**Y / N** High Blood Pressure	**Y / N** Rheumatism
Y / N Arthritis/Gout	**Y / N** Epilepsy or Seizures	**Y / N** High Cholesterol	**Y / N** Scarlet Fever
Y / N Artificial Heart Valve	**Y / N** Excessive Bleeding	**Y / N** Hives or Rash	**Y / N** Shingles
Y / N Artificial Joint	**Y / N** Excessive Thirst	**Y / N** Hypoglycemia	**Y / N** Sickle Cell Disease
Y / N Asthma	**Y / N** Fainting Spells or Dizziness	**Y / N** Irregular Heartbeat	**Y / N** Sinus Troubles
Y / N Blood Disease	**Y / N** Frequent Cough	**Y / N** Kidney Problems	**Y / N** Spina Bifida
Y / N Blood Transfusion	**Y / N** Frequent Diarrhea	**Y / N** Leukemia	**Y / N** Stomach/Intestinal Disease
Y / N Breathing Problem	**Y / N** Frequent Headaches	**Y / N** Liver Disease	**Y /N** Stroke
Y / N Bruise Easily	**Y / N** Genital Herpes	**Y / N** Low Blood Pressure	**Y / N** Swelling of Limbs
Y / N Cancer	**Y / N** Glaucoma	**Y / N** Lung Disease	**Y / N** Thyroid Disease
Y / N Chemotherapy	**Y / N** Hay Fever	**Y / N** Mitral Valve Prolapse	**Y / N** Tonsillitis
Y / N Chest Pains	**Y / N** Heart Attack/Failure	**Y / N** Osteoporosis	**Y / N** Tuberculosis (TB)
Y / N Cold Sores/Fever Blisters	**Y / N** Heart Murmur	**Y / N** Pain in Jaw Joints	**Y / N** Tumors or Growths
Y / N Congenital Heart Disorder	**Y / N** Heart Pacemaker	**Y / N** Parathyroid Disease	**Y / N** Ulcers
Y / N Convulsions	**Y / N** Heart Trouble/Disease	**Y / N** Psychiatric Care	**Y / N** Venereal Disease
			Y / N Yellow Jaundice

List any other serious illnesses not listed above: _____

Please rate your health from 1-10: 1 2 3 4 5 6 7 8 9 10

FOR WOMEN: **Are you taking birth control pills or other oral contraceptives?** O No O Yes _____
How many children have you had? _____ **Are you currently nursing?** O No O Yes
Are you pregnant? O No O Maybe O Yes

EMERGENCY CONTACT INFORMATION

Name: _____ **Relationship:** _____
Last First Middle Initial

Work phone # _____ **Extension** _____ **Home phone #** _____ **Mobile phone #** _____
Email address: _____

ABOUT YOU

Today's Date: ____/____/_____

Patient Name: _____ **What you prefer to be called:** _____
Last First Middle Initial

Date of birth: ____/___/_____ **Age:** _____ **Social Security #** _____ - _____ - _____ O Male O Female

Mailing address: _____ **City**: _____ **State:** _____ **Zip code**: _____
Subdiv_____ **Home phone #** _____ **Mobile phone #** _____ **Work phone #** _____
Email address: _____

Occupation: _____ **Employer**: _____**How long?** _____
Employer address: _____ **City**: _____ **State**:_____ **Zip code**: _____

Status: O Minor O Single O Married O Divorced O Separated O Widowed **Spouse's name**: _____
Do you have children? O No O Yes - How many? _____ **Names?** _____

For confirmation purposes, may we: O Email O Text message O Call you **Favorite song for iPod playlist**? _____
How you found us? _____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE:

Company Name: _____
Address: _____**City**: _____ **State**: _____**Zip code**: _____
Phone # _____ **Group # (Plan, Local, or Policy #)** _____
Insured Social Security # _____ - _____ - _____ **Relationship to insured:** _____ **Insured DOB:** ____/____/_____
Insured place of employment: _____

SECONDARY DENTAL INSURANCE:

Company Name: _____
Address: _____ **City**: _____ **State**: _____ **Zip code**: _____
Phone # _____ **Group # (Plan, Local, or Policy #)** _____
Insured Social Security # _____ - _____ - _____ **Relationship to insured:** _____ **Insured DOB:** ____/____/_____
Insured place of employment: _____

- **I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered and authorize the provider to release any information necessary to process insurance claims. I also understand that I am fully responsible for any balance not paid by my insurance company.** ***Signature*** _____

ACCOUNT INFORMATION

PERSON ULTIMATELY RESPONSIBLE FOR ACCOUNT:

Name: _____ **Relationship:** _____
Last First Middle Initial

Driver's License # _____ **Social Security #** _____ - _____ - _____ O Male O Female

Billing address: _____ **City**: _____**State**: _____**Zip code**: _____
Work phone # _____**Extension** _____ **Home phone #** _____ **Mobile phone #** _____
Email address: _____

- **We invite you to discuss with us any questions you may have regarding our services. We depend on a mutual understanding between provider and patient in order to optimize your dental health services. As such, we are focused on providing the patient with all the information necessary for them to make the best possible oral health decisions.**
- **We accept and file for most insurance policies and will always work to maximize your coverage. We also accept most major credit card and offer financing through Care Credit to those who qualify.**
- **I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information necessary to process insurance claims.**
- **I understand the above information and certify that this form was completed correctly, to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes to the information that I have provided.**

Signature of adult patient or parent/guardian of patient under the age of 18 _____ **Date** ____/____/_____