CONFIDENTIAL

PATIENT INFORMATION

Today's Date _____

(Please Print)

Patient Name _____ Birthdate _____ Age _____
FIRST MI LAST

What You Prefer to be Called _____ ☐ Male ☐ Female

Address _____ City _____ State _____ Zip _____

Preferred Phone # _____ Is this a mobile #? ☐ Yes ☐ No

Other Contact Phone # _____ E-Mail _____

Status ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Occupation _____

Spouse or Parent/Guardian Name (if minor) _____

Patient or Parent/Guardian Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

If Patient is Student, Name of School/College _____ City _____ State _____

Emergency Contact _____ Phone _____ Relation _____

Whom May We Thank for Referring You? _____

RESPONSIBLE PARTY / ACCOUNT INFORMATION

Name of Person Responsible for this Account _____

Relation _____ Birthdate _____ SS # _____

Address _____ City _____ State _____ Zip _____

Preferred Phone # _____ E-Mail _____ Employer _____

Is This Person Currently A Patient In Our Office? ☐ Yes ☐ No

INSURANCE INFORMATION

Primary Dental Insurance

Subscriber's Name _____ Relation _____
Subscriber's SS # _____ DOB _____
Insurance Name _____
Ins Phone # _____
Ins Address _____
_____
Employer Name _____
Subscriber ID # _____
Group # _____ Local # _____

Secondary Dental Insurance *(if applicable)*

Subscriber's Name _____ Relation _____
Subscriber's SS # _____ DOB _____
Insurance Name _____
Ins Phone # _____
Ins Address _____
_____
Employer Name _____
Subscriber ID # _____
Group # _____ Local # _____

Insurance Authorization

☐ By checking this box, I authorize my insurance company to pay the dentist all insurance benefits rendered. I authorize the use of my electronic signature on all insurance submissions. I authorize this dentist to release all information necessary to secure the payment of benefits. And, I understand that I am financially responsible for all charges whether or not paid by insurance.

PREFERRED PHARMACY

Pharmacy Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Team Initials _____ Updated Pt File _____

PATIENT MEDICAL HISTORY

Physician _____ Office Phone # _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now? _____	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness? _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, please list _____	☐	☐
_____		
_____		
4. **Do you require a pre-med prior to dental appointments**?	☐	☐
5. Are you taking a blood thinner?	☐	☐
6. Are you taking a daily aspirin or baby aspirin?	☐	☐
7. Are you currently or have you ever taken bisphosphonates for your bones *(e.g. Fosamax, Boniva, Zometa, Aredia)*?	☐	☐
8. Do you use cocaine or methamphetamine? *(reacts with anesthesia)*	☐	☐
9. Do you use any tobacco and/or vaping products?	☐	☐

10. **Allergies:** Check any allergic reactions you may have to the following:

☐ Local Anesthetics *(e.g. Novocaine)*	☐ Penicillin or other Antibiotics	Other *(describe)*
☐ Codeine	☐ Sedatives	_____
☐ Sulfa Drugs	☐ Nitrous	_____
☐ Latex	☐ Aspirin	_____

	Yes	No
11. Do you have a persistent cough or throat clearing not associated with known illness (lasting more than 3 weeks)?	☐	☐
12. Do you experience sleep apnea or snoring?	☐	☐
13. Women Only:		
a. Are you pregnant or think you may be pregnant?	☐	☐
b. Are you nursing?	☐	☐
c. Are you taking birth control pills? *(some antibiotics may alter the effectiveness of birth control pills)*	☐	☐

14. Check all medical conditions you have had or have presently:

☐ High Blood Pressure	☐ Joint Replacement/Joint Implant	☐ Stroke	☐ Stomach Issues/Ulcers
☐ Low Blood Pressure	☐ Liver Disease	☐ Thyroid Problem	☐ Sexually Trans. Disease
☐ Cardiac Pacemaker/Defibrillator	☐ Kidney Disease	☐ Shingles	☐ AIDS or HIV Infection
☐ Heart Complications	☐ Diabetes	☐ Excessive Bleeding/Bruising	☐ Hepatitis/Jaundice
Explain: _____	☐ Anemia or Blood Disorder	☐ Tuberculosis	Describe: _____
_____	☐ Leukemia	☐ Asthma	☐ Other Medical Considerations
☐ Rheumatic/Scarlet Fever	☐ Cancer/Tumors	☐ Sinus Issues/Allergies	_____
☐ Arthritis/Rheumatism	☐ Chemo/Radiation Therapy	☐ Fainting/Seizures/Dizziness	_____
☐ Glaucoma	☐ Respiratory Issues/Easily Winded	☐ Epilepsy/Convulsions	_____

PATIENT DENTAL HISTORY

1. What was the date of your last dental exam *(if not done here)*?
_____

	Yes	No
2. Do your gums bleed while brushing or flossing?	☐	☐
3. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
4. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
5. Do you feel pain to any of your teeth?	☐	☐
6. Do you have any sores or lumps in or near your mouth?	☐	☐
7. Have you had any head, neck or jaw injuries?	☐	☐
8. Have you ever experienced any of the following problems in your jaw?		
a. Clicking?	☐	☐
b. Pain (joint, ear, side of face)?	☐	☐
c. Difficulty in opening or closing?	☐	☐
d. Difficulty in chewing?	☐	☐

	Yes	No
9. Do you have frequent headaches or head injuries?	☐	☐
10. Do you clench or grind your teeth?	☐	☐
11. Do you bite your lips or cheeks frequently?	☐	☐
12. Have you ever had prolonged bleeding following extractions?	☐	☐
13. Have you ever had any difficult extractions in the past?	☐	☐
14. Have you had any orthodontic work?	☐	☐
15. Have you ever been treated for periodontal (gum) disease?	☐	☐

16. How happy are you with your smile (0-10)? _____

CONSENT

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
- I have received and understand the office's Financial Policy which requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office manager. If account is not paid within 60 days of the date of service and no financial arrangements have been made, I will be responsible for finance charges, legal fees, collection agency fees and any other expenses incurred in collecting my account.
- I understand the office's Appointment Policy. I may be charged a fee if I miss more than one appointment without 24-business hrs notice within 12-mths.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I provided.

X _____ _____

Patient Signature (Parent or Guardian) Date