# Welcome To Our Office

## Responsible Party

### Personal Information:

First Name _____ Initial _____ Last Name _____

Address _____ City _____ State _____ Zip Code _____

Home Phone# _____ Cell Phone# _____ Email _____

Birthdate _____ Age _____ Driver's License# _____ Issued State _____

Social Security# _____ Where Do You Do Your Banking _____

Nearest Relative Not Living With You _____ Address _____

Relative's Phone# _____

For your convenience, we offer the following payment methods. Circle the option you prefer.
Payment in full at each appointment.

[ Cash ] [ Personal Check ] [ Credit Card ] Visa Mastercard

### Employer Information:

Employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip Code _____

Work Phone# _____

### Spouse Information:

First Name _____ Initial _____ Last Name _____ Home Phone _____

Birthdate _____ Age _____ Employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip Code _____

### Child Information:

First Name _____ Initial _____ Last Name _____ Home Phone _____

Address _____ City _____ State _____ Zip Code _____

Birthdate _____ Age _____ Sex _____ School _____ City _____ Grade _____

### Insurance Information:

Primary Insurance Company _____

Insurance Address _____ City _____ State _____ Zip Code _____

Employee _____ SS# _____ Member# _____ Group# _____

Secondary Insurance Company _____

Insurance Address _____ City _____ State _____ Zip Code _____

Employee _____ SS# _____ Member# _____ Group# _____

Whom may we thank for referring you to our office? _____

Person to contact in case of emergency? _____ Address _____

Home Phone# _____ Work Phone# _____

Is another member of your family a patient at our practice? YES NO

Name _____

# 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 within the last 5 years? If yes, please explain _____ | ☐ | ☐ |
| 3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____ | ☐ | ☐ |
| 4. Do you use tobacco? | ☐ | ☐ |

6. Are you allergic to or have you had any reactions to the following:

| | Yes | No |
|---|---|---|
| Local Anesthetics (e.g. Novocain) | ☐ | ☐ |
| Penicillin or any other Antibiotics | ☐ | ☐ |
| Sulfa Drugs | ☐ | ☐ |
| Codeine | ☐ | ☐ |
| Sedatives | ☐ | ☐ |
| Demerol | ☐ | ☐ |
| Aspirin | ☐ | ☐ |
| Any Metals (e.g. nickel, mercury, etc.) | ☐ | ☐ |
| Latex Rubber | ☐ | ☐ |
| Other _____ | ☐ | ☐ |

7. Women Only:

| | Yes | No |
|---|---|---|
| Are you pregnant or think you may be pregnant? | ☐ | ☐ |
| Are you nursing? | ☐ | ☐ |
| Are you taking oral contraceptives? | ☐ | ☐ |

5. Do you have or have you had any of the following?

| | Yes | No |
|---|---|---|
| High Blood Pressure | ☐ | ☐ |
| Heart Attack | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ |
| Swollen Ankles | ☐ | ☐ |
| Fainting/Seizures | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| Low Blood Pressure | ☐ | ☐ |
| Epilepsy/Convulsions | ☐ | ☐ |
| Leukemia | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Kidney Diseases | ☐ | ☐ |
| AIDS or HIV Infection | ☐ | ☐ |
| Thyroid Problem | ☐ | ☐ |
| Nervousness | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Heart Disease | ☐ | ☐ |
| Cardiac Pacemaker | ☐ | ☐ |
| Heart Murmur | ☐ | ☐ |
| Angina | ☐ | ☐ |
| Frequently Tired | ☐ | ☐ |
| Anemia | ☐ | ☐ |
| Emphysema | ☐ | ☐ |
| Cancer | ☐ | ☐ |
| Arthritis | ☐ | ☐ |
| Joint Replacement or Implant | ☐ | ☐ |
| Hepatitis A, B or C | ☐ | ☐ |
| Sexually Transmitted Disease | ☐ | ☐ |
| Stomach Troubles/Ulcers | ☐ | ☐ |
| Cold Sores | ☐ | ☐ |
| Yellow Jaundice | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Chest Pains | ☐ | ☐ |
| Easily Winded | ☐ | ☐ |
| Stroke | ☐ | ☐ |
| Hay Fever/Allergies | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ |
| Radiation Therapy | ☐ | ☐ |
| Glaucoma | ☐ | ☐ |
| Recent Weight Loss | ☐ | ☐ |
| Liver Disease | ☐ | ☐ |
| Heart Trouble | ☐ | ☐ |
| Respiratory Problems | ☐ | ☐ |
| Mitral Valve Prolapse | ☐ | ☐ |
| Blood Transfusion | ☐ | ☐ |
| Other _____ | ☐ | ☐ |

# Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

| | Yes | No |
|---|---|---|
| 1. Do your gums bleed while brushing or flossing? | ☐ | ☐ |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | ☐ | ☐ |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | ☐ | ☐ |
| 4. Do you feel pain to any of your teeth? | ☐ | ☐ |
| 5. Do you have any sores or lumps in or near your mouth? | ☐ | ☐ |
| 6. Have you had any head, neck or jaw injuries? | ☐ | ☐ |
| 7. Do you like your smile? | ☐ | ☐ |
| 8. What would you like to change about your smile? _____ | | |
| 9. Do you wish your teeth were whiter? | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| 10. If any work is needed in the future would you prefer White Porc. or Silver Metal? _____ | | |
| 11. Do you clench or grind your teeth? | ☐ | ☐ |
| 12. Have you ever had any difficult extractions in the past? | ☐ | ☐ |
| 13. Have you ever had any prolonged bleeding following extractions? | ☐ | ☐ |
| 14. Have you had any orthodontic treatment? | ☐ | ☐ |
| 15. Do you wear dentures or partials? If yes, date of placement _____ | ☐ | ☐ |
| 16. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | ☐ | ☐ |

## Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. 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 the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent/guardian if minor)

Doctor's Comments _____

_____

_____

Signature _____ Date _____