

PATIENT INFORMATION

Welcome to our office!

The information provided is important to your dental health.

Patient's name _____ Preferred name _____ Birthdate _____

If minor, parent's names _____ Single Married Long Term Partner Divorced Widowed

Email _____ Home # _____ Cell # _____ Work # _____

Mailing address _____ City _____ State _____ ZIP _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____

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

BILLING, CREDIT AND INSURANCE INFORMATION: Not covered by insurance Your SSN _____

Dental insurance co. _____ Group # _____

Covered by spouse's insurance? Yes No Spouse's dental insurance co. _____ Group # _____

Spouse's birthdate _____ Spouse's SSN _____

DENTAL HISTORY

Chief oral complaint _____

Date of last dental exam _____ Any previous major dental treatment? _____

- | | | | |
|---|--|--|--|
| <input type="radio"/> Teeth sensitive to cold, heat, sweets or pressure | <input type="radio"/> Frequent blisters on lips or mouth | <input type="radio"/> Periodontal treatment | <input type="radio"/> Water jet device |
| <input type="radio"/> Bleeding gums. How long? _____ | <input type="radio"/> Pain around ear | <input type="radio"/> Orthodontic treatment | <input type="radio"/> Disclosing tablets or solution |
| <input type="radio"/> Food impaction | <input type="radio"/> Unusual sounds in ear while eating | <input type="radio"/> Mouth breathing | <input type="radio"/> Fluoride supplements |
| <input type="radio"/> Clenching or grinding | <input type="radio"/> Bad breath | <input type="radio"/> Oral habits: nail biting, cheek biting, etc. | <input type="radio"/> Alcohol |
| <input type="radio"/> Burning of tongue | <input type="radio"/> Unpleasant taste | <input type="radio"/> Texture of toothbrush? _____ | Do you smoke? <input type="radio"/> Yes <input type="radio"/> No |
| <input type="radio"/> Swelling or lumps in mouth | <input type="radio"/> Unfavorable dental experience | <input type="radio"/> Frequency of brushing? _____ | Do you use chewing tobacco? <input type="radio"/> Yes <input type="radio"/> No |
| | <input type="radio"/> Complications from extraction | <input type="radio"/> Dental floss | <input type="radio"/> Other _____ |

MEDICAL HEALTH HISTORY

Physician's name _____ Date of last physical exam _____ Age _____

- | | | | |
|--|---|---|--|
| <input type="radio"/> Allergies to drugs | <input type="radio"/> Excessive bleeding from cut or extraction | <input type="radio"/> Latex sensitivity | <input type="radio"/> Thyroid |
| _____ | <input type="radio"/> Anemia or blood problems | <input type="radio"/> Liver problems or hepatitis | <input type="radio"/> Eye |
| _____ | <input type="radio"/> Arthritis | <input type="radio"/> Malignancies | <input type="radio"/> Tonsilitis |
| <input type="radio"/> Allergies to anesthetics | <input type="radio"/> Chronic Fatigue Syndrome | <input type="radio"/> Psychiatric care/emotional problems | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Any heart ailments | <input type="radio"/> Asthma | <input type="radio"/> Rheumatic fever | <input type="radio"/> Ulcer or colitis |
| <input type="radio"/> High blood pressure | <input type="radio"/> Hay fever or allergies in general | <input type="radio"/> Sinus problems | <input type="radio"/> Pregnancy? If yes, what month? _____ |
| <input type="radio"/> Neurological problems | <input type="radio"/> Diabetes | <input type="radio"/> Immune system disorder (AIDS, HIV) | <input type="radio"/> Venereal disease |
| <input type="radio"/> Radiation treatments | <input type="radio"/> Kidney problems | <input type="radio"/> Stroke | <input type="radio"/> Other _____ |

Describe any current medical treatment including drugs taken, even though not listed above: _____

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointments without a 24 hour notification. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

INSURANCE: To avoid misunderstandings regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are responsible for payments/fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all of our fees. Each fee is individual for the individual patient.

Signature of patient (or parent) _____ Date _____