



We are pleased to welcome you and/or your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

## PATIENT INFORMATION

Date \_\_\_\_\_ Occupation \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_ Patient Employer/School \_\_\_\_\_

Patient Name \_\_\_\_\_ Employer/School Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Employer/School Phone (\_\_\_\_\_) \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Spouse's Name \_\_\_\_\_

E-mail \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Married  Widowed  Single  Minor

Separated  Divorced  Partnered for \_\_\_\_\_ years

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## DENTAL INSURANCE

Subscriber's Name \_\_\_\_\_ Is patient covered by secondary insurance?  Yes  No

Relationship to Patient \_\_\_\_\_ Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Group # \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_ Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

## PHONE NUMBERS

Home (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_

Spouse's Work (\_\_\_\_\_) \_\_\_\_\_ Best time and place to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household.)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

## DENTAL HISTORY

Reason for today's visit \_\_\_\_\_

Former Dentist \_\_\_\_\_

City/State \_\_\_\_\_

Date of last dental visit \_\_\_\_\_

Date of last dental X-rays \_\_\_\_\_

How often do you floss? \_\_\_\_\_

How often do you brush? \_\_\_\_\_

Do you wear contact lenses?  Yes  No

**Please check (✓) "yes" or "no" to indicate if you have had any of the following:**

Bad breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lip or cheek biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth or broken fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning sensation on tongue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chew on one side of mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cigarette, pipe, or cigar smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clicking or popping jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fingernail biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold	<input type="checkbox"/> Yes <input type="checkbox"/> No
Food collection between the teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat	<input type="checkbox"/> Yes <input type="checkbox"/> No
Foreign objects in mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets	<input type="checkbox"/> Yes <input type="checkbox"/> No
Grinding teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gums swollen or tender	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No



# MEDICAL HISTORY



Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Pharmacy \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Please check (✓) "yes" or "no" to indicate if you have had any of the following:

- |                             |  |                          |  |  |  |
|-----------------------------|--|--------------------------|--|--|--|
| AIDS                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV Positive             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors or Growths                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease            | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| Chemical Dependency         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure       | <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Have you ever had or been diagnosed with:</b> |  |
| Chemotherapy                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Artificial Heart Valves                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Artificial Joints, Screws, Pins, etc.            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bleeding abnormally, with extractions or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent or bloody | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood Disease                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Congenital Heart Lesions                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia Repair                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fainting or dizziness       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glaucoma                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet/Weight Loss | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Headaches                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Problems              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles   | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| Hepatitis Type _____        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands      | <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Are you allergic to:</b>                      |  |
| Herpes                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Aspirin  | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**Have you ever had any complications following dental treatment?**  Yes  No

If yes, please describe \_\_\_\_\_

Have you ever been hospitalized or do you have any other health concerns?  Yes  No

If yes, please describe \_\_\_\_\_

**Women:** Are you pregnant?  Yes  No

Due date \_\_\_\_\_

Are you nursing?  Yes  No

Taking birth control pills?  Yes  No

**Have you ever taken any of these medications?**

- |                  |  |
|------------------|--|
| Blood Thinners   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Coumadin         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Warfarin         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diet Medications | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dexfenfluramine  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fen-phen         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pondimin         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Redux            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Levoxyl          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Synthroid        | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**Please PRINT all medications now taking:** \_\_\_\_\_

### SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

**Insurance Assignment:** I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_ Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

**Authorization to Release Protected Health Information:** I understand that there may be a need to consult with other health care providers. I voluntarily authorize

Dr. \_\_\_\_\_ to use and/or disclose my Protected Health Information (PHI) related to \_\_\_\_\_ Describe in detail the Protected Health Information

\_\_\_\_\_. The information will be used and/or disclosed for the purpose of \_\_\_\_\_ Describe each purpose for which you are authorizing you are authorizing to be used and/or disclosed.

\_\_\_\_\_. I authorize Dr. \_\_\_\_\_ Name of Doctor Receiving PHI to receive and use the information. your Protected Health Information to be used and/or disclosed.

This authorization will end when my current treatment plan is completed or one year from the date signed below. I understand that once the information is released it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization at any time by notifying, in writing, the above-named doctor disclosing the PHI. However, if I do revoke this authorization, it will not have any effect on any actions taken by the above-named doctor disclosing the PHI prior to their receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization. I understand I may refuse to sign this authorization.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient



# DOCTOR'S COMMENTS & UPDATE

(to be completed by the dentist)



Medical Clearance Letter Sent to \_\_\_\_\_ Date \_\_\_\_\_

Results \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_