Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # ________________
SS#/SIN ________________
Date ________________

Patient Information (CONFIDENTIAL)

Name ________________ Birthdate ________________ Home Phone ________________

Address ________________ City ________________ State/Prov. ________ Zip/P.C. ________

Email ________________ Cell Phone ________________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

School/College ________________ Hobbies: ________________ Kids: ________________ Pets: ________________

Patient's Employer ________________ Work Phone ________________

Job Title ________________

Spouse or Parent/Guardian's Name ________________ Employer ________________ Work Phone ________________

Whom may we thank for referring you? ________________

Person to contact in case of emergency ________________ Phone ________________

Responsible Party

Name of Person Responsible for this Account ________________ Relationship to Patient ________________

Address ________________ Home Phone ________________

Email ________________ Cell Phone ________________

Driver's License # ________________ Birthdate ________________ Financial Institution ________________

Employer ________________ Work Phone ________________ SS#/SIN ________________

Is this person currently a patient in our office? ☐ Yes ☐ No

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

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured ________________ Relationship to Patient ________________

Birthdate ________________ SS#/SIN ________________ Date Employed ________________

Name of Employer ________________ Union or Local # ________________ Work Phone ________________

Address of Employer ________________ City ________________ State/Prov. ________ Zip/P.C. ________

Insurance Company ________________ Group # ________________ Policy/ID # ________________

Ins. Co. Address ________________ City ________________ State/Prov. ________ Zip/P.C. ________

How much is your deductible? ________________ How much have you used? ________________ Max. annual benefit ________________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured ________________ Relationship to Patient ________________

Birthdate ________________ SS#/SIN ________________ Date Employed ________________

Name of Employer ________________ Union or Local # ________________ Work Phone ________________

Address of Employer ________________ City ________________ State/Prov. ________ Zip/P.C. ________

Insurance Company ________________ Group # ________________ Policy/ID # ________________

Ins. Co. Address ________________ City ________________ State/Prov. ________ Zip/P.C. ________

How much is your deductible? ________________ How much have you used? ________________ Max. annual benefit ________________

Over Please

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. Have you ever taken Fen-Phen/Redux?	☐	☐
4. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
5. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
6. Do you use tobacco?	☐	☐

8. 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	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Seasonal Allergies	☐	☐
Food Allergies: ______________		
Other (please list) ______________		
9. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

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

	Yes	No		Yes	No		Yes	No
Heart Disease / Trouble	☐	☐	Diabetes	☐	☐	Anxiety	☐	☐
Cardiac Pacemaker	☐	☐	Arthritis	☐	☐	ADHD	☐	☐
Heart Murmur	☐	☐	Joint Replacement / Implant	☐	☐	Autism	☐	☐
Mitral Valve Prolapse	☐	☐	Glaucoma	☐	☐	Developmental Disorders	☐	☐
Chest Pains	☐	☐	Kidney Disease	☐	☐	Learning / Communication		
Heart Attack	☐	☐	Thyroid Problem	☐	☐	Disorders	☐	☐
Angina	☐	☐	Stomach Troubles	☐	☐	Eating Disorders	☐	☐
High Blood Pressure	☐	☐	Liver Disease	☐	☐	Bulemia / Anorexia	☐	☐
Low Blood Pressure	☐	☐	Cancer	☐	☐	Mood Disorder	☐	☐
Stroke	☐	☐	Radiation Therapy	☐	☐	Drug Abuse	☐	☐
Respiratory Problems	☐	☐	Chemotherapy	☐	☐	Alcohol Abuse	☐	☐
Rheumatic Fever	☐	☐	Sexually Transmitted Disease	☐	☐	Previous Drug Rehabilitation	☐	☐
Frequent / Persistent Cough	☐	☐	AIDS / HIV Infection	☐	☐	TMJ Pain	☐	☐
Asthma	☐	☐	Epilepsy / Convulsions	☐	☐	Swollen Ankles	☐	☐
Emphysema	☐	☐	Fainting / Seizures	☐	☐	Leukemia	☐	☐
Tuberculosis	☐	☐	Dementia / Alzheimers	☐	☐	Anemia	☐	☐
Hepatitis / Jaundice	☐	☐	Vertigo	☐	☐	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. Do you feel pain to any of your teeth?	☐	☐
4. Do you have any sores or lumps in or near your mouth?	☐	☐
5. Do you have frequent headaches?	☐	☐
6. Do you clench or grind your teeth?	☐	☐
7. Have you ever had any difficult extractions in the past?	☐	☐
8. Have you ever had any prolonged bleeding following extractions?	☐	☐
9. Have you had any orthodontic treatment?	☐	☐
Who? ______________		

Current Medication List

Are you taking any medication(s) including non-prescription medicine? ☐ ☐

If yes, what medication(s) are you taking? ______________

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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) Date

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