PATIENT INFORMATION

Date_____

Name_____ Preferred Name _____
Last Name *First Name* *Initial*

Soc. Sec. #_____

Address _____

City _____ State _____ Zip _____ Cell Phone_____

Home Phone_____ Email _____

Gender _____ Age_____ Birthdate_____

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced ❑ Partnered

Patient Employed by _____ Occupation _____

Business Phone _____

Whom may we thank for referring you? _____

Notify in case of emergency_____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account_____
Last Name *First Name* *Initial*

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient)_____ Home Phone _____

City _____ State _____ Zip_____

Person Responsible Employed by _____

Insurance Company _____ Phone_____

Insurance Address _____

Group #_____ Subscriber #_____

DENTAL HISTORY

Date of last dental care _____ Date of last x-rays_____

Check (✓) yes or no if you currently have problems with any of the following:

❑ Y ❑ N Bad breath	❑ Y ❑ N Food collection between teeth	❑ Y ❑ N Periodontal treatment	❑ Y ❑ N Sensitivity to sweets
❑ Y ❑ N Bleeding gums	❑ Y ❑ N Grinding or clenching teeth	❑ Y ❑ N Sensitivity to cold	❑ Y ❑ N Sensitivity when biting
❑ Y ❑ N Clicking or popping jaw	❑ Y ❑ N Loose teeth or broken fillings	❑ Y ❑ N Sensitivity to hot	❑ Y ❑ N Sores or growths in mouth

How often do you brush? _____ Floss?_____

Do you use an Electric Toothbrush? _____ Flouride Rinse?_____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Other information about your dental health or previous treatment _____

Please complete both sides.

Medical History

Physician's name _____ Phone _____

Date of last visit _____

Are you currently under physician care? ❑ Y ❑ N If yes, describe _____

Have you ever taken Fen-Phen/Redux? ❑ Y ❑ N

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ❑ Y ❑ N

Do you smoke or use other tobacco/smokeless products? ❑ Y ❑ N Please circle all that apply: Cigarettes Cigars Vape Marijuana Chew Other _____

Women: Are you pregnant? ❑ Y ❑ N Due Date_____ Nursing? ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N

Check (✔) yes or no whether you have had any of the following:

❑ Y ❑ N AIDS/HIV Positive
❑ Y ❑ N Allergies
❑ Y ❑ N Anemia
❑ Y ❑ N Arthritis, Rheumatism
❑ Y ❑ N Artificial heart valves
❑ Y ❑ N Artificial joints
❑ Y ❑ N Asthma
❑ Y ❑ N Blood disease
❑ Y ❑ N Cancer
❑ Y ❑ N Chemical dependency
❑ Y ❑ N Chemotherapy
❑ Y ❑ N Circulatory problems
❑ Y ❑ N Diabetes
❑ Y ❑ N Epilepsy
❑ Y ❑ N Fainting
❑ Y ❑ N Food allergies
❑ Y ❑ N Glaucoma
❑ Y ❑ N Headaches
❑ Y ❑ N Heart murmur
❑ Y ❑ N Heart problems
Describe _____
❑ Y ❑ N Abnormal bleeding
❑ Y ❑ N Hepatitis
❑ Y ❑ N High blood pressure
❑ Y ❑ N Low blood pressure
❑ Y ❑ N Kidney disease or malfunction
❑ Y ❑ N Liver disease
❑ Y ❑ N Material allergies (**latex**, wool, metal, chemicals)
❑ Y ❑ N Mitral valve prolapse
❑ Y ❑ N Nervous problems
❑ Y ❑ N Pacemaker/ Heart surgery
❑ Y ❑ N Psychiatric care
❑ Y ❑ N Radiation treatment
❑ Y ❑ N Respiratory disease
❑ Y ❑ N Rheumatic/Scarlet fever
❑ Y ❑ N Stroke
❑ Y ❑ N Sinus problem
❑ Y ❑ N Swollen neck gland
❑ Y ❑ N Thyroid disease or malfunction
❑ Y ❑ N Tobacco habit
❑ Y ❑ N Ulcer/Colitis

Are you currently taking any medications? If yes, list all:

_____

_____

_____

Do you have any drug allergies? If yes, list all:

_____

_____

_____

Medical History Update

Has there been any change in the patient's health since the last dental apporintment? ❑ Y ❑ N

For what conditions? _____

Is the patient taking any new medications? _____ If so, what?_____

_____ _____

Date Patient Signature

Medical History Update

Has there been any change in the patient's health since the last dental apporintment? ❑ Y ❑ N

For what conditions? _____

Is the patient taking any new medications? _____ If so, what?_____

_____ _____

Date Patient Signature

Medical History Update

Has there been any change in the patient's health since the last dental apporintment? ❑ Y ❑ N

For what conditions? _____

Is the patient taking any new medications? _____ If so, what?_____

_____ _____

Date Patient Signature

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date_____

Payment is due in full at time of treatment, unless prior arrangements have been approved.