Today's Date _____

Patient Information

Name: _____ Male: _____ Female: _____
Last First MI Mr. Mrs. Ms Dr

Single: ___ Married: ___ Divorced: ___ Widowed: ___ Separated: ___ I prefer to be called: _____

Birthdate: _____/_____/_____ Social Security #: _____-_____-_____ Driver License #: _____

Home Address: _____
Street City State Zip Code

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____ Ext_____

When are the best times to reach you? _____ Whom may we thank for referring you? _____

Employer: _____ How long there? _____ Occupation: _____

Person Responsible for Account if other then yourself

His/Her Name: _____ Relation: _____ Home #: _____ Cell #: _____

Employer: _____ Work #: _____ Ext _____ Birthdate: _____/_____/_____

Billing Address: _____
Street City State Zip Code

Relative or Neighbor not living with you

His/Her Name: _____ Relation: _____ Home #: _____ Cell #: _____

Dental History

Why have you come to the dentist today? _____

	Yes	No
Are you currently in pain?	☐	☐
Do you require antibiotics before dental treatment?	☐	☐
Have you ever experienced problems associated with any previous dental work?	☐	☐
Have you ever experienced any pain / discomfort with your jaw joint (TMJ / TMD)?	☐	☐
Your current dental health is	Good ☐ Fair ☐ Poor ☐	
Do you floss daily? Yes ☐ No ☐	Brush Daily? ☐	☐
Type of bristles on your toothbrush?	Hard ☐ Med ☐ Soft ☐	
How long do you use a toothbrush before replacing it? _____		
Do you use anything in addition to your brush and floss?	☐	☐
If yes what? _____		
Would you like fresher breath? Yes ☐ No ☐ Whiter teeth?	☐	☐
Do you smoke or use tobacco in any other form?	☐	☐

	Yes	No
Do your gums ever bleed? Yes ☐ No ☐ Ever Itch?	☐	☐
Have you ever had periodontal disease?	☐	☐
Do you have mobility in your teeth?	☐	☐
Are your teeth sensitive to heat, cold, or anything else? _____		
Do you still have wisdom teeth?	☐	☐

Previous Dentist: _____ Last Visit Date: _____
Why did you leave your previous dentist? _____
_____

Are you happy with the way your smile looks? ☐ ☐
If not, what would you change? _____
_____

Medical History

Do you have a person physician? Yes ☐ No ☐
Physician's Name: _____
Address: _____
Phone #: _____ Date of last visit: _____

Your current physical health is: Good ☐ Fair ☐ Poor ☐
Are you currently under the care of a physician? Yes ☐ No ☐
Please explain: _____
_____

For women:

Are you taking birth control pills? Yes ☐ No ☐
Are you pregnant? Unsure ☐ Yes ☐ No ☐
Week Number: _____ Are you nursing? Yes ☐ No ☐

Are you allergic to any of the following? (Please check all that apply.)

Aspirin ☐
Barbiturates ☐
Codeine ☐
Dental Anesthetics ☐
Erythromycin ☐
Jewelry/ Metals ☐
Latex ☐
Penicillin ☐
Sedatives ☐
Sulfa Drugs ☐
Tetracycline ☐
Other ☐

Please list additional drugs/ materials that cause allergic reactions: _____

Are you taking any of the following? (Please check all that apply.)

Acetaminophen ☐
Antibiotics ☐
Antihistamines ☐
Aspirin ☐
Blood Thinners ☐
Blood Pressure Medication ☐
Cold Remedies ☐
Digitalis/ Heart Medication. ☐
Insulin/ Diabetes Drugs ☐
Nitroglycerin ☐
Recreational Drugs ☐
Steroids/ Cortisone ☐
Thyroid Medicine ☐
Tranquilizers ☐

Are you taking any prescriptions, over the counter drugs, herbal remedies, vitamins or minerals not listed above? ☐ Yes ☐ No If yes, please list each one:

_____
_____

Do you or have you experienced the following? (Please check all that apply.)

Abnormal Bleeding ☐
Alcohol Abuse (AA) ☐
Anemia ☐
Arthritis ☐
Artificial Bones/Joints ☐
Artificial Valves ☐
Asthma ☐
Blood Transfusion ☐
Cancer (CA) ☐
Chemotherapy ☐
Chicken Pox ☐
Colitis ☐
Congenital Heart Defect ☐
Diabetes ☐
Difficulty Breathing ☐
Drug Abuse (DA) ☐
Emphysema ☐
Epilepsy ☐
Fainting Spells ☐
Fever Blisters ☐
Glaucoma ☐
Hay Fever ☐
Headaches ☐
Heart Attack ☐
Heart Murmur ☐
Heart Surgery ☐
Hemophilia ☐
Hepatitis (Hep) ☐
Herpes (HSV) ☐
High Blood Pressure(HBP) ☐
HIV+/AIDS(H+) ☐
Hospitalized for Any Reason ☐
Kidney Problems ☐
Low Blood Pressure(LBP) ☐
Lupus ☐
Mitral Valve Prolapse (MVP) ☐
Ostroporosis/Paget's Disease ☐
Pacemaker ☐
Persistent Cough ☐
Psychiatric Problems (Psy) ☐
Radiation Treatment ☐
Rheumatic Fever ☐
Scarlet Fever ☐
Seizures ☐
Shingles ☐
Sickle Cell Disease ☐
Sinus Problems ☐
Steroid Therapy ☐
Stroke ☐
Thyroid Problems ☐
Tonsillitis ☐
Tuberculosis (TB) ☐
Ulcers ☐
Venereal Disease (VD) ☐

Authorizations

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be _____.

_____
Signature Date

I certify that I am covered by _____ Insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature Date

PAYMENT IS DUE AT THE TIME OF SERVICES BEING RENDERED.