DENTAL HISTORY

What would you like us to do today?_____ Are you in dental discomfort today? _____
Former Dentist_____ Address _____ Phone_____
Date of last dental care_____Date of last x-rays _____
Check (✓) yes or no if you have had problems with any of the following:
❒ Y ❒ N Bad breath ❒ Y ❒ N Food collection between teeth ❒ Y ❒ N Periodontal treatment ❒ Y ❒ N Sensitivity to sweet
❒ 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
Do you feel pain to any of your teeth? ❒ Y ❒ N Have you had any head, neck or jaw injuries? ❒ Y ❒ N
Pain (joint, ear, side of face)? ❒ Y ❒ N Difficulty in opening or closing? ❒ Y ❒ N Difficulty in chewing? ❒ Y ❒ N
Do you have frequent headaches? ❒ Y ❒ N Have you had any orthodontics? ❒ Y ❒ N
Have you ever had any prolonged bleeding following extractions? ❒ Y ❒ N
How often do you brush?_____ Floss?_____
How do you feel about the appearance of your teeth: _____
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 _____

MEDICAL HISTORY

Physician's name_____ Phone _____
Date of last visit_____ Have you had any serious illnesses or operations? ❒ Y ❒ N
If yes, describe_____
Are you currently under physician care? ❒ Y ❒ N If yes, describe _____
Have you ever had a blood transfusion? ❒ Y ❒ N If yes, give approximate dates _____
Do you smoke or use tobacco in any other form? ❒ Y ❒ N
Are you wearing contact lenses? ❒ Y ❒ N
Are you taking osteoporosis medication? ❒ Y ❒ N If yes, what kind?_____ how long? _____
Are you allergic to or have had any reactions to the following:

Dental Anesthetics	❒ Y ❒ N	Penicillin or other Antibiotics	❒ Y ❒ N
Sulfa Drugs	❒ Y ❒ N	Codeine	❒ Y ❒ N
Sedatives	❒ Y ❒ N	Latex	❒ Y ❒ N
Aspirin	❒ Y ❒ N	Jewelry/Metals	❒ Y ❒ N

Women: Are you pregnant? ❒ Y ❒ N Nursing? ❒ Y ❒ N Taking birth control pills? ❒ Y ❒ N Do you have breast implants? ❒ Y ❒ N

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

❒ Y ❒ N AIDS/HIV Positive
❒ Y ❒ N Allergies (seasonal)
❒ Y ❒ N Anaphylaxis
❒ Y ❒ N Anemia
❒ Y ❒ N Angina Pectoris
❒ Y ❒ N Arthritis, Rheumatism
❒ Y ❒ N Artificial heart valves
❒ Y ❒ N Artificial joints/Bones
❒ Y ❒ N Asthma
❒ Y ❒ N Atopic (allergy prone)
❒ Y ❒ N Back problems
❒ Y ❒ N Blood disease
❒ Y ❒ N Cancer
❒ Y ❒ N Chemical dependency
❒ Y ❒ N Chemotherapy
❒ Y ❒ N Circulatory problems
❒ Y ❒ N Colitis
❒ Y ❒ N Congenital Heart
❒ Y ❒ N Cortisone treatments
❒ Y ❒ N Cosmetic Surgery
❒ Y ❒ N Cough, persistent
❒ Y ❒ N Cough up blood
❒ Y ❒ N Diabetes
❒ Y ❒ N Difficulty Breathing
❒ Y ❒ N Emphysema
❒ Y ❒ N Epilepsy
❒ Y ❒ N Fainting
❒ Y ❒ N Food allergies
❒ Y ❒ N Frequent headaches
❒ Y ❒ N Glaucoma
❒ Y ❒ N Hay fever
❒ Y ❒ N Headaches
❒ Y ❒ N Heart Attack
❒ Y ❒ N Heart murmur
❒ Y ❒ N Heart problems
Describe _____
❒ Y ❒ N Hemophilia/ Abnormal bleeding
❒ Y ❒ N Herpes/Fever blisters
❒ Y ❒ N Hepatitis A, B or C
❒ Y ❒ N High blood pressure
❒ Y ❒ N Jaundice
❒ Y ❒ N Jaw pain
❒ Y ❒ N Kidney disease or malfunction
❒ Y ❒ N Liver disease
❒ Y ❒ N Low blood pressure
❒ Y ❒ N Material allergies (latex, wool, metal, chemicals)
❒ Y ❒ N Mitral valve prolapse
❒ Y ❒ N Nervous problems
❒ Y ❒ N Pacemaker/ Heart surgery
❒ Y ❒ N Pneumocysis
❒ Y ❒ N Psychiatric care
❒ Y ❒ N Rapid weight gain or loss
❒ Y ❒ N Radiation treatment
❒ Y ❒ N Respiratory disease
❒ Y ❒ N Rheumatic/Scarlet fever
❒ Y ❒ N Seizures
❒ Y ❒ N Shingles
❒ Y ❒ N Shortness of breath
❒ Y ❒ N Sickle Cell Disease
❒ Y ❒ N Sinus problems
❒ Y ❒ N Skin rash
❒ Y ❒ N Stroke
❒ Y ❒ N Surgical implant
❒ Y ❒ N Swelling of feet or ankles
❒ Y ❒ N Thyroid disease or malfunction
❒ Y ❒ N Tobacco habit
❒ Y ❒ N Tonsilitis
❒ Y ❒ N Ulcer/Colitis
❒ Y ❒ N Venereal disease

Is patient currently taking any medications? If yes, list all:

_____
_____
_____
_____

Does patient have drug allergies? If yes, list all:

_____
_____
_____
_____

WELCOME

We are pleased to welcome you to our practice. 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: _____

Acct. # _____

Name _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email (optional) _____

Sex ❒ M ❒ F Age _____ Birthdate _____ ❒ Single ❒ Married ❒ Widowed ❒ Separated ❒ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Spouse or Parent's Name _____

If Patient is a Student, Name of School / College _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____ Cell 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 _____ Cell Phone _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber# _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ❒ Yes ❒ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address *(if different from patient)* _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____ Cell Phone _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber # _____

AUTHORIZATION AND RELEASE

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 _____

Please complete both sides. • **PAYMENT IS DUE IN FULL AT TIME OF TREATMENT**