Welcome

Today's Date: ________________

Thank you for choosing our Practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

PATIENT INFORMATION

Name ____ Birthdate ____________ ☐ **Male** ☐ **Female**
First MI Last

Home Address____________________________________ City____________________ State_____ Zip________
Home Phone # ________________________ Work # ________________________ Cell # ____________________

Do you prefer to receive calls at: ☐ Home ☐ Work ☐ Cell Phone Best Time to call: ____________

Are you: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Other
Spouse/Parents Name ____________________________________ Occupation ___________________________
If a Student, name of school/college __________________________ City ______________ State _____ Zip _______
Person to contact in case of emergency ___________________________________ Phone # __________________
Relation to Patient __________________________
Whom may we thank for referring you to us? ____

RESPONSIBLE PARTY

Name of person responsible for account ______________________________ Relationship to patient _____________
Birthdate _________________ Social Security # ________________________ Driver's License # ________________
**E-mail Address ____
Employer ______________________________ Occupation __________________________________
Address if different from above _____________________________ City _______________ State _____ Zip ______
Home # _________________________ Work # __________________________

DENTAL INSURANCE INFORMATION

Primary Insurance		**Secondary Insurance**	
Insurance Company	__________________________	**Insurance Company**	__________________________
Group Number	__________________________	**Group Number**	__________________________
Name of Insured	__________________________	**Name of Insured**	__________________________
Relationship to Patient	__________________________	**Relationship to Patient**	__________________________
Insured's Birthdate	__________________________	**Insured's Birthdate**	__________________________
Social Sec. Num,	__________________________	**Social Sec. Num,**	__________________________
Employer	__________________________	**Employer**	__________________________
Date Employed	__________________________	**Date Employed**	__________________________

AUTHORIZATION AND RELEASE

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 payers and/or other 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 dependants.

X____
Signature of patient or parent/guardian of minor Date

I acknowledge that I have received a copy
of the Facts About Fillings.

____
(Patient, Parent/Guardian signature) (Date)

I acknowledge that I have received a copy
of the Notice Of Privacy Practices.

____
(Patient, Parent/Guardian signature) (Date)

MEDICAL HISTORY

Patients Name ____
LAST FIRST MI DATE OF BIRTH

CIRCLE THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

COMMENTS

1. Are you under a physician's care? _ YES NO
   - If yes ...
   - Since when ____________________________ Why? ___________________________
   - Physician's Name____
   - Address ____
   ________________________________TEL: ( ) ___________________________
2. When was your last complete physical exam? ___________________________________

(Please circle if you have or had any of the following)

3. Has you health changed in the last year _ YES NO
4. Any Latex Allergies _ YES NO
5. Bleeding problems, Bruise easily _ YES NO
6. Headaches, Ringing in ears _ YES NO
7. Joint pain or Stiffness, Arthritis _ YES NO
8. Fainting or seizures _ YES NO
9. Heart disease, Murmurs, Rheumatic fever,
   Prosthetic heart valve, Irregular heartbeat _ YES NO
10. Pacemaker _ YES NO
11. High or Low Blood pressure (please circle) _ YES NO
12. Diabetes _ YES NO
13. Cortisone Medicine _ YES NO
14. Tumors, Cancer _ YES NO
15. Radiation treatment _ YES NO
16. Depression _ YES NO
17. Kidney or Bladder disease _ YES NO
18. Problems with penicillin, antibiotics, anesthetics
    or other medications (please list) _ YES NO
19. Are you taking any medication or substances _ YES NO
    - If yes: Please list medications in comments section or on back of form.
20. Do you routinely take health related substances
    (ie: Vitamins, herbal supplements, natural products) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ YES NO
21. Have you ever had a serious illness or major surgery _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ YES NO
    If yes, explain ____
22. Have you ever had radiation treatment, any growth or other conditions _ _ _ _ _ _ _ _ _ YES NO
23. Any Allergies or Hives_ YES NO
24. Any kidney problems_ YES NO
25. Any stomach problems_ YES NO
26. Do you use any birth control medications _ YES NO
27. Are you Pregnant/Expecting _ YES NO
    - If yes: Month _________________
28. Smoke, chew, use snuff or any other forms of tobacco _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ YES NO
29. Cold sores, Fever blisters, Herpes _ YES NO
30. Do you or have you had venereal disease _ YES NO
31. Hepatitis or Liver disease _ YES NO
32. TB, Asthma or Lung disease _ YES NO
33. HIV positive, AIDS, ARC _ YES NO
34. Have you had psychiatric treatment _ YES NO
35. Do you have any disease, condition or problem not listed _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ YES NO
    -If yes, Explain ____
36. Is there anything else we should know about your health that we have not covered in this form?
    ____
37. Would you like to speak to the Doctor privately about any problem _ _ _ _ _ _ _ _ _ _ _ YES NO
38. Are you taking any Bisphophonates (osteoporosis medications)
    oral or intravenous (ie: Alendronate, Fosamax) ? _ YES NO

I CERTIFY THAT ALL OF THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S/GUARDIAN'S SIGNATURE _______________________________ DATE ____________________

DENTIST'S SIGNATURE ____ DATE ____________________

ANEST MED. ALERT

DENTAL HISTORY

Patients Name ____
LAST FIRST MI DATE OF BIRTH

CIRCLE THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

COMMENTS

1. Purpose of today's visit ______________________________
   ____
2. Are you aware of any problems with your teeth ______________________________
   ____
   - If so, have you consulted with any other dentist about this . . . . YES NO
   - If yes what was discussed or done? ______________________________
   ____
3. When was your last dental & cleaning check up? ______________________________
4. Who was your previous dentist? ______________________________

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

5. When were your last dental x-rays? ______________________________
6. Have you lost any teeth or have any been removed? . . . . YES NO
   Why? ______________________________
7. Have they been replaced? . . . . YES NO
8. How have they been replaced?
   a. Fixed bridge ______________ Age ______________
   b. Removable bridge ______________ Age ______________
   c. Denture ______________ Age ______________
   d. Implant ______________ Age ______________
9. Are you unhappy with the replacement? . . . . .YES NO
   If yes, explain ______________________________
10. Would you like to know about permanent replacements? .YES NO
11. Have you ever had any problems or complications with previous dental treatment? . . YES NO
    If yes, explain: ______________________________
12. Do you clench or grind your teeth? . . . . .YES NO
13. Does your jaw click or pop? . . . . YES NO
14. Have you experienced any pain or soreness in muscles, your face
    or around your ears? . . . . .YES NO
15. Do you have frequent headaches, neck aches or shoulder aches? . . . . YES NO
16. Does food get caught in your teeth? __________ When? ______________________________
17. Are your teeth sensitive to: ☐ Hot ☐ Cold ☐ Sweets ☐ Pressure ☐ None
18. Do your gums bleed or hurt? . . . . YES NO
    When? ______________________________
19. How often do you brush your teeth? ______________ When? ______________
20. Do you use dental floss? . . . . YES NO
    How often? ______________________________
21. Are any of your teeth loose, tipped, shifted or chipped? . . . . YES NO
22. Are you unhappy with the appearance of your teeth? . . . . YES NO
23. How do you feel about your teeth in general? ______________________________
24. Do you feel your breath is offensive at times? . . . . .YES NO
25. Have you ever had gum treatment or surgery? . . . . .YES NO
    For What? ______________________________
    Where? ______________________________
    When? ______________________________
26. Have you had any orthodontic work? . . . . .YES NO
27. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? ______________________________
28. Do you have any questions or concerns? ______________________________

I CERTIFY THAT ALL OF THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S/GUARDIAN'S SIGNATURE ______________________________ DATE ______________

DENTIST'S SIGNATURE ______________________________ DATE ______________

ANEST ☐ MED. ALERT ☐

Welcome to our practice

CHILD DENTAL MEDICAL HISTORY

Patient's Name ____
Last First Initial Nickname Date of Birth

Parent's/Guardian's Name ____

DENTAL HISTORY – CIRCLE THE APPROPIATE ANSWER

COMMENTS

1. Is your child's first visit to a dentist? .... YES NO
2. If not, how long since the last visit to the dentist? ______________________________________
3. Where any x-rays or radiographs taken when your child previously visited the dentist? .... YES NO
4. Does your child eat between meals? .... YES NO
5. Does your child eat sweets such as candy, soda pop, chewing gum? .... YES NO
6. When does your child brush his/her teeth?
   □ Upon arising □ After eating any food □ Right after meals □ Before going to bed
7. How does your child receive Fluoride?
   □ Community water Level _ _ _ ppm □ Well Water Level _ _ _ ppm
   □ Fluoride drops or tab □ Fluoride rinse or gel
8. Have any cavities been noted in the past? .... YES NO
9. Where any teeth (baby or permanent) remove by extraction? .... YES NO
10. Have there been any inquires to teeth, such as falls, blows, chips, etc? .... YES NO
   If so describe ____
11. Has your child had any problem with dental treatment in the past? .... YES NO
12. Has anyone in the family, including parents, had orthodontics? .... YES NO
13. Has your child ever received a local anesthetic? .... YES NO
14. Has your child ever had occlusal sealants? .... YES NO
15. Does your child think there is anything wrong with his/her teeth? .... YES NO

MEDICAL HISTORY

1. Does your child have a health problem? .... YES NO
2. Is your child under the care of a physician? .... YES NO
   If yes, since when and why? ____
3. Name of physician ____
   Phone
4. Is your child receiving any medication? .... YES NO
   What? ____
5. Is your child allergic to penicillin, antibiotics or other drugs? .... YES NO
6. Is your child allergic or sensitive to any metals or latex? .... YES NO
7. Does your child have other allergies? .... YES NO
8. Has your child had any serious illness? .... YES NO
   When ______________________ What ______________________
9. Has your child ever had surgery? .... YES NO
10. Does your child have a heart murmur? .... YES NO
11. Is surgery contemplated? .... YES NO
12. Does your child experience severe or prolonged bleeding? .... YES NO
13. Does your child have AIDS or has he/she tested HIV positive? .... YES NO
14. Has your child tested positive for hepatitis? .... YES NO
15. Is your child subject to nervous disorders? .... YES NO
   □ Fainting? □ Seizures? □ Dizziness? □ Behavioral/Learning problems?
16. Does your child have frequent headaches? .... YES NO
17. Has your child had history of : (Circle appropriate response) diabetes, heart trouble, asthma, kidney infection rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Patient's/Guardian's Signature ____ Date ___________________________

Dentist's Signature ____ Date ___________________________