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| *Welcome to our office! Thank you for completing the following confidential form.* *Please fill out all pages front and back.**The information requested will assist us in treating you safely.*PATIENT INFORMATION

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Last name:  | First:  | Middle:  |  | Marital Status:  |
| Is this your legal name? | If not, what is your legal name? | Former name: | Birth date: | Age: | Gender: |
|  |  |  | [Birthday] |  |  |

Address:

|  |  |  |  |
| --- | --- | --- | --- |
| Social Security Number: | Home Phone: | Cell Phone: | Email: |
|  |  |  |  |
| Emergency Contact | Name: | Relationship: | Contact number: |
| Occupation: | Employer: | Employer Address: | Employer phone: |
|  |  |  |  |

Would you like to receive appointment reminders via text message or email? YES or NO

|  |  |  |
| --- | --- | --- |
| Whom may we thank for referring you to our practice? |  |  |
|  |  |  |

INSURANCE INFORMATION (Please give your insurance card to the receptionist.)**□ NO DENTAL INSURANCE**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Dental Insurance Company: | Employer: | Member ID: | Group #: | Are you the primary insured? |
|  |  |  |  |  |

If you’re not the primary insured, your relationship to primary subscriber:

|  |  |  |  |
| --- | --- | --- | --- |
| Primary Insured Name: | Primary Insured Birth Date: | Primary Insured SSN/ID#: | Policy #: |
|  |  |  |  |

**DENTAL HISTORY** When was your last dental visit? What was completed during your last visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last dental x-rays?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often do you have dental examinations? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How often do you brush your teeth? \_\_\_\_\_\_\_ How often do you floss? \_\_\_\_\_ Do you use other dental aids? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you have any dental problems that you are aware of now? If yes, please describe. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you feel nervous about dental treatment? If yes, what is your biggest concern? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
|  |

Have you taken any prescription drugs during the last 6 months? Please list. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES NO

Are you taking any over the counter medications or herbal supplements? Please list. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES NO

Are you allergic to (i.e. itching, rash,swelling of hands, feet, eyes) or made sick by any medication? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES NO

 Any surgeries and/or hospitalizations? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES NO

Have you ever had any excessive bleeding requiring special treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES NO

Have you ever taken drugs by mouth or by injection to strengthen bone for conditions such as osteoporosis, multiple myeloma, Paget’s disease, breast or prostate cancer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES NO

Have you ever been told to take antibiotics prior to dental treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES NO

Use of alcohol: YES NO Use of recreational drugs: YES NO Do you use tobacco? YES NO

(WOMEN) Are you pregnant now? YES NO Are you breastfeeding? YES NO Plan to become pregnant? YES NO

**PLEASE CIRCLE ANY OF THE FOLLOWING MEDICAL CONDITIONS YOU HAVE NOW OR HAVE HAD IN THE PAST**

Heart Disease/Heart Murmur

Heart Attack/Heart Failure

High/Low Blood Pressure

Diabetes Type I/II

Angina Pectoris

Artificial Heart Valve

Stroke

Heart Pacemaker

Joint Replacement Surgery

Chemo/Radiation Treatment

Cancer

Excessive bleeding

Anemia

Leukemia

Arthritis

Asthma/Bronchitis

Emphysema/COPD

Acid Reflux/Ulcers

Thyroid/Gland Problems

Seizures/Epilepsy

Osteoporosis

Tuberculosis

Rheumatic Fever

Kidney Problems

Sinus Problems

Psychiatric Care

HIV/AIDS

Hepatitis/Jaundice

Liver Failure

Herpes

Venereal Disease

Allergies to anesthetics

**PLEASE CIRCLE ANY OF THE FOLLOWING DENTAL CONDITIONS YOU HAVE NOW OR HAVE HAD IN THE PAST**

Sensitivity to hot/cold

Sensitivity to sweets

Sensitivity to biting/chewing

Bleeding or painful gums

Loose teeth

Shifting teeth

Food trap in between teeth

Clenching or grinding

Clicking or popping of the jaw

Pain in the jaw near the ear

Difficulty opening or closing

Headaches/migraines/neck or shoulder ache

Mouth breather

Chew foreign objects (ice, pencils, bite on nails etc)

**\*To the best of my knowledge all of the preceding answers are true and correct. If I ever have a change in my health, I will inform the office at the next appointment. I do hereby authorize and request for myself or the above named patient, dental services and/or whatever procedures the doctor may deem necessary. I authorize my insurance benefits to be paid directly to the dentist. I understand that I am financially responsible for any balance. I also authorize the dental office to release any information required to process my insurance claims. I understand that when necessary for me to reschedule an appointment, the office requires 24 hour notice. If the required notice is not given, a fee may be charged. I have read the office’s notice of privacy practice act (HIPAA) and I understand that I can obtain a copy of this form from the office if I request it.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE OF PATIENT OR GUARDIAN PRINT NAME DATE