

Welcome to our Practice!

Will you please help us by providing us with the following confidential information?

PATIENT INFORMATION:

Last Name: _____ First Name: _____

Preferred to be called: _____ Email Address: _____

Mailing Address: _____

City, State, Zip: _____ Date of Birth: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preference for Confirmation (please check): Email Cell Phone Home Phone Work Phone

SS#: _____ Sex: Male Female Occupation: _____

Employer: _____ Address, City, State, Zip: _____

Emergency Contact Name: _____ Phone Number: _____

Whom may we thank for referring you to our office?: _____

INSURANCE INFORMATION:

Primary Insurance Company: _____ Phone #: _____

Address, City, State, Zip: _____

Policy Holder Name: _____ SS#: _____

Birth Date: _____ Group or Policy #: _____

Secondary Insurance Information: _____ Phone #: _____

Address, City, State, Zip: _____

Policy Holder Name: _____ SS#: _____

Birth Date: _____ Group or Policy #: _____

I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. This release is solely for the purpose of facilitating the billing and reimbursement, directly to Dr. (Provider's Name) of insurance benefits under which I am entitled. I hereby agree that I am financially responsible for all treatment rendered, and understand that complete payment will be made after each treatment, unless other financial arrangements have been previously arranged.

Date: _____ Patient's Signature: _____

MEDICAL HEALTH HISTORY

Yes No Have you ever been told by a physician or dentist that you require premedication prior to dental treatment? If so what medication have you taken in the past?

Yes No Have there been any change in your health within the last year?
Explain:

Yes No Have you been hospitalized or had a serious illness in the last 5 years?
Explain:

Yes No Are you being treated by a physician now?
For what?

Name of your physician: _____ Date of last Medical Exam: _____

HAVE YOU EVER EXPERIENCED:

Yes	No	Chest pains	Yes	No	Snoring problems
Yes	No	Swollen ankles	Yes	No	Frequent headaches
Yes	No	Bruise easily	Yes	No	Fainting spells
Yes	No	Prolonged bleeding	Yes	No	Seizures
Yes	No	Sinus condition	Yes	No	Excessive thirst
Yes	No	Dizziness	Yes	No	Dry mouth
Yes	No	Jaundice	Yes	No	Sleep apnea

DO YOU HAVE OR HAVE YOU HAD:

Yes	No	Asthma	Yes	No	Osteoporosis/Osteopenia
Yes	No	Heart disease	Yes	No	HIV positive or AIDS
Yes	No	Heart attack	Yes	No	Cancer
Yes	No	Heart defects	Yes	No	Arthritis
Yes	No	Heart murmur	Yes	No	Rheumatoid arthritis
Yes	No	Rheumatic fever	Yes	No	Glaucoma
Yes	No	Stroke	Yes	No	Skin disease
Yes	No	High blood pressure	Yes	No	Anemia
Yes	No	Tuberculosis	Yes	No	VD (Syphilis or gonorrhea)
Yes	No	Hepatitis	Yes	No	Herpes
Yes	No	Ulcers	Yes	No	Kidney disease
Yes	No	Diabetes	Yes	No	Thyroid disease
Yes	No	Prostate problems	Yes	No	Radiation treatments
Yes	No	Chemotherapy	Yes	No	Artificial joint
Yes	No	Contact lenses	Yes	No	Prosthetic heart valve
Yes	No	Psychiatric care	Yes	No	Pacemaker
Yes	No	Hearing loss	Yes	No	Parkinson's disease
Yes	No	Reflux disease	Yes	No	Tumors
Yes	No	Emphysema			

DO YOU TAKE OR HAVE YOU TAKEN:

Yes No Recreational drugs Yes No Alcohol
Yes No Tobacco in any form Yes No Phen Phen or other diet pills

Women Only:

Yes No Birth Control Pills Yes No Pregnant/ nursing

ALLERGIES: Please list any known allergies to medications, foods, metals, etc

MEDICATIONS AND VITAMINS:

DENTAL HEALTH HISTORY

Name of previous dentist: _____ Date of last visit: _____

Is keeping your teeth important to you? _____

On a scale of 1-10, with 10 being the best, how would you rate your smile? _____

On a scale of 1-10, with 10 being the best, how would you rate your oral health? _____

How many times a day do you brush your teeth? _____ How many times a day do you floss? _____

Have you ever been diagnosed with sleep apnea? Yes No Not Sure

Are you currently being treated for obstructive sleep apnea? Yes No Not Sure

Have you been told (or noticed on your own) that you snore on most nights? Yes No Not Sure

Have you been told (or noticed on your own) that you stop breathing or struggle to breathe in your sleep?
Yes No Not Sure

Are you tired, fatigued, or sleepy on most days? Yes No Not Sure

Do you have acid indigestion or high blood pressure (OR use a medication to control either of these conditions)?
Yes No Not Sure

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING:

Yes No Bleeding gums Yes No Sensitivity to Hot/ Cold
Yes No Bad breath or sour taste in mouth Yes No Snoring
Yes No Burning Sensations in Mouth Yes No Food Catching Between Teeth
Yes No Soreness in Jaw Yes No Grinding of Teeth
Yes No Difficulty Opening Wide Yes No Pain Near Ears
Yes No Clicking or Popping Jaw Yes No Stiff Neck Muscles
Yes No Familial History of Gum Disease Yes No Parents with Dentures
Yes No Braces Yes No Head/ Jaw Injury

Yes No Oral Surgery Yes No Smoke/ Chew Tobacco
Yes No Treatment for Gum Disease Yes No Dental Emergency

Does having dental treatment make you afraid or nervous? Yes No

If yes, what specific things bother you?

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE WHICH OF THE FOLLOWING WOULD YOU CHOOSE?

Whiter	Close Spaces	Repair Chipped Teeth
Replace Missing Teeth	Replace Old Crowns	Remove Silver Fillings
Remove Stains	Straighter	Healthier

PLEASE CHECK WHICH OF THE FOLLOWING ARE IMPORTANT TO YOU WHEN MAKING YOUR ORAL HEALTH DECISIONS.

Convenience	Appearance	Relationship with Dental Team
Finances	Time	Quality of Care
What Insurance Covers	Health	Detailed Treatment Explanations
Fear or Anxiety	Comfort	Technology

To the best of my knowledge, I attest that the above is true and correct.

Date: _____ **Patient's Signature:** _____