

Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, **please fill out this form completely in ink.** If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (CONFIDENTIAL)

Date _____

Name _____ Birthdate _____ Home Phone _____
Last First M.I.

Address _____ City _____ State _____ Zip _____

Phone () _____ Bus. Phone () _____ Cell () _____ Soc. Security _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

If Student Full Time or Part Time Email: _____

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Relationship _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ Social Security # _____

Is this Person Currently a Patient in our Office? Yes No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash Personal Check Credit Card VISA MasterCard Debit Card American Express Discover

I certify that I have read and understand the above information to the best of my knowledge. I understand that I am responsible to pay as services rendered. I understand that I am responsible for any fees that will acquire for legal action being taken to collect my debt. I further understand that if a payment becomes 30 days past due, delinquency at the lesser of the annual rate 18%, or the maximum allowable rate, will be due on delinquent amounts from the date the payment was due. I acknowledge that there is a fee for bounced checks and that I may lose my rights to use checks. Our office is entitled to a minimum of 48 hours cancellation notice. **We reserve the right to charge cancellation fees for missed or broken appointments.**

Patient Signature

Witness Signature

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Insurance Company _____ Group # _____ Policy/ID # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

I authorize and request my insurance company to pay directly to the dentist of dental group insurance benefits otherwise payable to me, **I acknowledge that after thirty-days my account may acquire interest. After 45 days if insurance does not pay, I will be responsible for my account.**

Patient Signature

****Over Please****

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

- | | | | |
|--|---|---|---|
| <p>1. Are you under medical treatment now? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain _____</p> <p>3. Are you taking any medication(s) including non-prescription medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what medication(s) are you taking? _____</p> <p>4. Have you ever taken Phen-Fen/Redux? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Do you use controlled substances? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Are you wearing contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Do you have or have you had any of the following?</p> <table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"> <p>High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Swollen Ankles <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fainting / Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Epilepsy / Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Kidney Diseases <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>AIDS or HIV Infection <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Thyroid Problem <input type="checkbox"/> Yes <input type="checkbox"/> No</p> </td> <td style="width: 50%;"> <p>Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cardiac Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Angina <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequently Tired <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Joint Replacement or Implant <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hepatitis / Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sexually Transmitted Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stomach Troubles / Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No</p> </td> </tr> </table> | <p>High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Swollen Ankles <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fainting / Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Epilepsy / Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Kidney Diseases <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>AIDS or HIV Infection <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Thyroid Problem <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cardiac Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Angina <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequently Tired <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Joint Replacement or Implant <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hepatitis / Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sexually Transmitted Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stomach Troubles / Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>9. Are you allergic to or have you had any reactions to the following? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Local Anesthetics (e.g. Novocain) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Penicillin or any other Antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sulfa Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Barbiturates <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sedatives <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Iodine <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any Metals (e.g. nickel, mercury, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Latex Rubber <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other (please list) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Women Only:</p> <p>a) Are you pregnant or think you may be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c) Are you taking oral contraceptives? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chest Pains <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Easily Winded <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hay Fever / Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Radiation Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Recent Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Respiratory Problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Covid-19 <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| <p>High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Swollen Ankles <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fainting / Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Epilepsy / Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Kidney Diseases <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>AIDS or HIV Infection <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Thyroid Problem <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cardiac Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Angina <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequently Tired <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Joint Replacement or Implant <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hepatitis / Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sexually Transmitted Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stomach Troubles / Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | | |

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

- | | |
|---|---|
| <p>1. Do your gums bleed while brushing or flossing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Are your teeth sensitive to hot or cold liquids/foods? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are your teeth sensitive to sweet or sour liquids/foods? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Do you feel pain to any of your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you have any sores or lumps in or near your mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you had any head, neck or jaw injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Have you ever experienced any of the following problems in your jaw?</p> <p>Clicking? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pain (joint, ear, side of face)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficulty in opening or closing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficulty in chewing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>8. Do you have frequent headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Do you clench or grind your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Do you bite your lips or cheeks frequently? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Have you ever had any difficult extractions in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Have you ever had any prolonged bleeding following extractions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Have you had any orthodontic treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Do you wear dentures or partials? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, date of placement _____</p> <p>15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Do you like your smile? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|---|---|

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. 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 and/or health Practitioners.

X _____
Signature of patient (or parent/guardian if minor)

Doctor's Signature _____ Comments _____ Date _____