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Patient Information

Date__________________ Email Address______________________________________

First Name_________________ Last Name__________________ Middle Initial______ Name I prefer to be called_______________

Birth date___________ Age____ Social Security #________________ ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Home Address____ City___________________ State_______ Zip__________

Mailing Address____ City___________________ State_______ Zip__________

Home Phone________________ Work Phone_________________ Cell Phone_______________ Drivers Lic#:_________________

How were you referred to our practice? ○Website ○Direct Mailer ○Drive-by

Were you referred by one of our current patients? Yes No If so who? ____

Employer____ Occupation___________________ Years of Employment __________

Employer's Address____ City___________________ State_______ Zip__________

Spouse or Emergency Contact Information

Name_______________________________________ Birth date________________ Relationship__________________

Home Phone___________________ Work Phone____________________ Cell Phone___________________

Primary Insurance Information

Insurance Company____ Phone #_____________________ Group #_____________

Insurance Company Claim Mailing Address __________________________________City____________ State_____ Zip________

Name of Insured_________________________ Insured's Social Security #__________________ Insured's Birth date_____________

Insured's Address____ City___________________ State_______ Zip__________

Relationship to Insured: ○Self ○Spouse ○Child ○Other ________________________ Insured's Employer_____________________

Medical History

Do you have a personal physician? Yes No Physicians Name_______________________ Phone #_________________________

Are you under a physician's care now? Yes No If yes, please explain: ____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: ___________________________________

Have you ever had a serious head or neck injury? Yes No If yes, please explain: ____________________________________

Are you on a special diet? Yes No

Do you use tobacco of any kind? Yes No

Are you taking blood thinners of any kind? Yes No If yes, please explain: ____________________________________

Do you take, or have you taken, Phen-Fen or Redux? Yes No

Have you ever taken Bisphosphonates (Fosamax Boniva) ? Yes No If yes, when did you take it and for how long?__________________

Do you require antibiotics before dental treatment? Yes No

Please list all prescription and over the counter medications you are taking including dosage.

____

____

For Women Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Do you have, or have you had, any of the following?

Condition			Condition			Condition			Condition		
AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No	Dry Mouth Xerostomia	Yes	No
Acid Reflux/GERD	Yes	No	HPV	Yes	No	Gout	Yes	No	Alcohol Abuse	Yes	No
Physical Abuse	Yes	No									

Have you ever had any serious illness not listed above? Yes No If yes, please explain:____________________

____

____

Are you allergic to any of the following?

Aspirin	Yes No	Codeine	Yes No	Erythromycin	Yes No	Latex	Yes No	Tetracycline	Yes No
Barbiturates	Yes No	Local Anesthetics	Yes No	Metals	Yes No	Penicillin	Yes No	Sulfa Drugs	Yes No

Please list anything additional that causes an allergic reaction ____________________

Please list anything that you have sensitivity to ____________________

I understand that, under Health Insurance Portability & Accountability Act of 1996 (HIPPA) I have certain rights to privacy regarding my protected health information. I have been given access to the offices notice of privacy practices. I understand that I may request in writing how my private information is disclosed to carry out treatment, payment, or healthcare operations

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE ____________________ DATE __________

Medical History Update

I have reviewed my medical history and updated anything that has changed since the original signing of this document.

SIGNATURE ____________________ DATE __________

SIGNATURE ____________________ DATE __________

SIGNATURE ____________________ DATE __________

SIGNATURE ____________________ DATE __________

SIGNATURE ____________________ DATE __________

Dental History

What brings you into the office today?

____

Are you in discomfort? Yes No If yes please answer the following questions:

Where in your mouth? Upper Right Lower Right Upper Left Lower Left Upper Front Lower Front

What causes the discomfort? Biting/Chewing Cold Hot Hurts on its own

How long have you been experiencing discomfort? ______________________

Past history

When was your last dental exam with x-rays? ____________ When was your last dental cleaning? ____________

Were there any treatment recommendations made that were not completed? Yes No

What obstacle prevented you from doing the recommended dental treatment? ______________________

Do you have missing teeth? Yes No If yes what type of restoration fills the space? Dental Implant Bridge Partial Denture None

Circle the treatments you have had. Fillings Crowns Root Canal Porcelain Veneer Dental Implant Deep Cleaning Bridge Extraction Partial Denture Whitening

Do you have any broken teeth? Yes No

Do you have any loose teeth? Yes No

How important to you is keeping the teeth you have for the rest of your life not important 1 2 3 4 5 very important

Aesthetics

How happy are you with the appearance of your smile? dislike 1 2 3 4 5 like

Is there anything about your smile that you would like to change? Shade/Color Spaces Crowding Gum Height Shape Size/Length

Have you ever worn braces? Yes No If yes when ____________

Have you ever whitened your teeth? Yes No If yes what product did you use? ______________

TMJ

Have you ever experienced any of the following problems with your jaw? Clicking Popping Pain in the joint Ringing in the ears Difficulty opening and closing Difficulty chewing

Do you have frequent headaches? Yes No Do you notice signs of wear such as chips or worn down edges? Yes No

Do you wear a night guard, or has one been recommended to you? Yes No Do you clench or grind your teeth? Yes No

Home Routine

How many times a day do you brush? __________ Do you use a manual or an electric toothbrush? __________

Do you floss? Yes No If yes, How often? ________ Do your gums bleed when you brush or floss? Yes No

We want to make every visit comfortable and individualized to your personal needs. This checklist helps us prevent unnecessary repetition of stress you may have encountered in the past. Please check all that apply.

- ☐ I don't want to be lectured about the condition of my mouth
- ☐ I gag easily
- ☐ I have anxiety about injections
- ☐ I have not been to the dentist in a long time and I am worried about what the dental team will think or say
- ☐ Respect my time – I don't want to be waiting in the reception room
- ☐ Pain relief is a top priority
- ☐ I usually use an anti-anxiety medication for dental treatment
- ☐ I want to be able to instantly communicate during dental treatment by raising my hand or other signal
- ☐ It is important that all procedures are explained to me at each visit.
- ☐ I want to know the fees for treatment reviewed with me at each visit
- ☐ I have difficulty listening and remembering what I hear while sitting in the dental chair.
- ☐ I want to know everything about the condition of my mouth and what it will take to restore it to dental health
- ☐ I don't like the sound of the drill
- ☐ I have problems with my back
- ☐ I prefer longer appointments and less return visits

Previous Dentist ______________________ Why did you leave your last dentist? ______________________