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 SSN/ SIN_____

Date_____

Patient Information (Confidential)

Name_____Birthdate_____Home Phone_____

Address_____City_____State_____Zip_____

Email_____Cell Phone_____

Check Appropriate Box: ( ) Minor ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated

If Student, Name of School_____City_____State_____ ( ) Full-Time ( ) Part-Time

Patient or Parent/ Guardian's Employer_____ Work Phone_____

Business Address_____City_____State_____Zip_____

Spouse or Parent/Guardian's Name_____Employer_____Work Phone_____

Whom May We Thank for Referring You?_____

Person to Contact in Case of Emergency_____Phone_____

Responsible Party

Name of Person Responsible for this Account_____Relationship to Patient_____

Address_____Home Phone_____

Email_____Cell Phone_____

Driver's License#_____Birthdate_____SSN/SIN_____

Employer_____Work Phone_____

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

Insurance Information

Name of Insured_____Relationship to Patient_____

Birthdate_____SSN/SIN_____Date Employed_____

Name of Employer_____Union or Local#_____Work Phone_____

Address of Employer_____City_____State_____Zip_____

Insurance Company_____Group #_____Policy/ID#_____

Ins. Co. Address_____City_____State_____Zip_____

How Much is your Deductible?_____How Much Have You Used?_____Max. Annual Benefit_____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? ( ) Yes ( ) No IF YES, COMPLETE THE FOLLOWING

Name of Insured_____Relationship to Patient_____

Birthdate_____SSN/SIN_____Date Employed_____

Name of Employer_____Union or Local#_____Work Phone_____

Address of Employer_____City_____State_____Zip_____

Insurance Company_____Group #_____Policy/ID#_____

Ins. Co. Address_____City_____State_____Zip_____

How Much is your Deductible?_____How Much Have You Used?_____Max. Annual Benefit_____

*****OVER PLEASE*****

Patient Medical History

Physician_____Office Phone_____Date of Last Exam_____

	Yes	No
1. Are you under medical treatment now?	( )	( )
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years. If yes, Please explain_____	( )	( )
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking?_____	( )	( )
4. Have you ever taken Fen-Phen/Redux?	( )	( )
5. Have you ever taken Fosamax/Actonel/Boniva	( )	( )
6. Do you use tobacco?	( )	( )
7. Do you use controlled substances?	( )	( )
8. Are you wearing contact lenses?	( )	( )
9. Do you snore?	( )	( )
10. Do you have sleep apnea?	( )	( )
11. Have you ever been told you snore?	( )	( )

13. Are you allergic to or have you had any reactions to the following?	Yes	No
Local Anesthetics (e.g. Novocain)	( )	( )
Penicillin or any other Antibiotics	( )	( )
Sulfa Drugs	( )	( )
Barbiturates	( )	( )
Sedatives	( )	( )
Iodine	( )	( )
Aspirin	( )	( )
Any Metals (e.g. nickel, mercury, etc.)	( )	( )
Latex Rubber	( )	( )
Other (please list)_____	( )	( )
14. Do you have persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)	( )	( )
15. Women Only:		
a) Are you pregnant or think you may be pregnant?	( )	( )
b) Are you nursing?	( )	( )
c) Are you taking oral contraceptives?	( )	( )
d) Do you have HPV	( )	( )

12. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	( )	( )	Heart Disease	( )	( )	Chest Pains	( )	( )
Heart Attack	( )	( )	Cardiac Pacemaker	( )	( )	Easily Winded	( )	( )
Rheumatic Fever	( )	( )	Heart Murmur	( )	( )	Stroke	( )	( )
Swollen Ankles	( )	( )	Angina	( )	( )	Hay Fever / Allergies	( )	( )
Fainting / Seizures	( )	( )	Frequently Tired	( )	( )	Tuberculosis	( )	( )
Asthma	( )	( )	Anemia	( )	( )	Radiation Therapy	( )	( )
Low Blood Pressure	( )	( )	Emphysema	( )	( )	Glaucoma	( )	( )
Epilepsy / Convulsions	( )	( )	Cancer	( )	( )	Recent Weight Loss	( )	( )
Leukemia	( )	( )	Arthritis	( )	( )	Liver Disease	( )	( )
Diabetes	( )	( )	Joint Replacement or Implant	( )	( )	Heart Trouble	( )	( )
Kidney Diseases	( )	( )	Hepatitis / Jaundice	( )	( )	Respiratory Problem	( )	( )
AIDS or HIV Infection	( )	( )	Sexually Transmitted Disease	( )	( )	Mitral Valve Prolapse	( )	( )
Thyroid Problem	( )	( )	Stomach Troubles / Ulcers	( )	( )	Other _____	( )	( )

Patient Dental History

Name of Previous Dentist and Location_____Date of Last Exam_____

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

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 payors and/or 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 dependents.**

X_____ **X**_____

Patient Signature Doctor Signature Date

Clear Form