# Patient Information (CONFIDENTIAL)

ASA _____

Soc. Sec. # _____

Birthdate _____

Name _____ Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Email _____

If Student, Name of School/College _____ City _____ State _____ ☐ Full Time ☐ Part Time

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

Spouse or Parent'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 _____

Birthdate _____ SS # _____ Home Phone _____

Employer _____ Work Phone _____ Cell 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. Payments in full at each appointment.

☐ Cash ☐ Personal Check ☐ Credit Card ☐ VISA ☐ Master Card ☐ I wish to discuss the office's payment policy.

# Insurance Information

Name of Insured _____ Relationship To Patient _____

Birthdate _____ SS # _____ Date Employed _____

Name of Employer _____ Work Phone _____

Insurance Company _____ Group # _____ Policy ID # _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING

Name of Insured _____ Relationship To Patient _____

Birthdate _____ SS # _____ Date Employed _____

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

Insurance Company _____ Group # _____ Policy ID # _____

**APPOINTMENTS:** A minimum charge may be made for failed or cancelled appointments without prior notification of 24 hours. This fee covers only a portion of the overhead such as, salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

**INSURANCE:** To avoid misunderstanding regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that the patient's are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

Signature _____ Date _____

(Parent or Guardian, if Patient is a Minor)

# Patient Dental History

**Patient Name** _____

**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 your teeth? | ☐ | ☐ |
| 10. Do you bite your lips or cheeks frequently? | ☐ | ☐ |
| 11. Have you ever had difficult extractions in the past? | ☐ | ☐ |
| 12. Have you ever had any prolonged bleeding following extractions? | ☐ | ☐ |
| 13. Have you ever had any orthodontic treatment? | ☐ | ☐ |
| 14. Do you have 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? | ☐ | ☐ |

**Use this area to explain or expand upon any of your answers.**

# 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 past 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 Phen-Fen/Redux? | ☐ | ☐ |
| 5. Do you use tobacco? | ☐ | ☐ |
| 6. Do you use controlled substances? | ☐ | ☐ |
| 7. Are you wearing contact lenses? | ☐ | ☐ |
| 9. Are you allergic to or have you had any reactions to the following? | | |
| Local Anesthetics (e.g. Novocaine) | ☐ | ☐ |
| Penicillin or any other Antibiotics | ☐ | ☐ |
| Sulfa Drugs | ☐ | ☐ |
| Barbiturates | ☐ | ☐ |
| Sedatives | ☐ | ☐ |
| Iodine | ☐ | ☐ |
| Aspirin | ☐ | ☐ |
| Any Metals (e.g. nickel, mercury etc.) | ☐ | ☐ |
| Latex Rubber | ☐ | ☐ |
| Other (please list below) | ☐ | ☐ |
| 10. Women Only: | | |
| a) Are you pregnant/think you may be pregnant? | ☐ | ☐ |
| b) Are you nursing? | ☐ | ☐ |
| c) Are you taking oral contraceptives? | ☐ | ☐ |

**8. Do you have or have you had any of the following?**

| | Yes | No |
|---|---|---|
| High Blood Pressure | ☐ | ☐ |
| Low Blood Pressure | ☐ | ☐ |
| Heart Disease | ☐ | ☐ |
| Heart Attack | ☐ | ☐ |
| Cardiac Pacemaker | ☐ | ☐ |
| Angina | ☐ | ☐ |
| Easily Winded | ☐ | ☐ |
| COPD | ☐ | ☐ |
| Swollen Ankles | ☐ | ☐ |
| Stroke | ☐ | ☐ |
| Epilepsy / Convulsions | ☐ | ☐ |
| Fainting / Seizures | ☐ | ☐ |
| Respiratory Problems | ☐ | ☐ |
| Hay Fever / Allergies | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| Emphysema | ☐ | ☐ |
| Frequently Tired | ☐ | ☐ |
| Anemia | ☐ | ☐ |
| Leukemia | ☐ | ☐ |
| Thyroid Problem | ☐ | ☐ |
| Stomach Troubles / Ulcers | ☐ | ☐ |
| Liver Disease | ☐ | ☐ |
| Hepatitis / Jaundice | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Cancer | ☐ | ☐ |
| Radiation Therapy | ☐ | ☐ |
| Recent Weight Loss | ☐ | ☐ |
| Glaucoma | ☐ | ☐ |
| Arthritis | ☐ | ☐ |
| Joint Replacement or Implant | ☐ | ☐ |
| Sexually Transmitted Disease | ☐ | ☐ |
| AIDS or HIV Infection | ☐ | ☐ |
| Other _____ | ☐ | ☐ |

**Use this area to explain or expand upon any of your answers.**