

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)

Patient # _____
SS#/SIN _____
Date _____
Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State/Prov. _____ Zip/P.C. _____
Email _____ Cell Phone _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If Student, Name of School/College _____ City _____ State/Prov. _____ ☐ Full Time ☐ Part Time
Patient or Parent/Guardian's Employer _____ Work Phone _____
Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____
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 _____ Financial Institution _____
Employer _____ Work Phone _____ SS#/SIN _____
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 ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE?

☐ Yes

☐ No

IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
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 | | Yes | No |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Are you under medical treatment now? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Are you wearing contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? | <input type="checkbox"/> | <input type="checkbox"/> | 11. Are you allergic to or have you had any reactions to the following? | | |
| If yes, please explain | | | Local Anesthetics (e.g. Novocain) | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Penicillin or any other Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you taking any medication(s) including non-prescription medicine? | <input type="checkbox"/> | <input type="checkbox"/> | Barbiturates | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, what medication(s) are you taking? | | | Sedatives | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Iodine | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever taken Fen-Phen/Redux? | <input type="checkbox"/> | <input type="checkbox"/> | Any Metals (e.g. nickel, mercury, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? | <input type="checkbox"/> | <input type="checkbox"/> | Latex Rubber | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? | <input type="checkbox"/> | <input type="checkbox"/> | Other (please list) | | |
| 7. Do you use tobacco? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 8. Do you use controlled substances? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you have or have you had any of the following? | | | 13. Women Only: | | |
| | | | a) Are you pregnant or think you may be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | b) Are you nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | c) Are you taking oral contraceptives? | <input type="checkbox"/> | <input type="checkbox"/> |

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

Patient Dental History

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

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

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

Signature of patient (or parent/guardian if minor)

Date _____

Doctor's Comments

Signature _____

Date _____

Oral Health Risk Factors

Patient's Name: _____

1. Do you smoke or have you **EVER** smoked?

(If No, proceed to question 2)

☐ Yes ☐ No

The amount that you are presently smoking (Check ALL that apply)

_____ None (quit smoking completely)

_____ An occasional cigarette

_____ A few cigarettes per day

_____ Less than 1 pack of cigarettes per day

_____ 1-2 packs of cigarettes per day

_____ 2 or more packs of cigarettes per day

_____ An occasional cigar

_____ Cigars on a daily/regular basis

_____ An occasional pipe

_____ A pipe on a daily/regular basis

If you quit smoking, when did you quit?

_____ Less than 6 months ago

_____ 6 months to a year ago

_____ 1 to 3 years ago

_____ Over 3 years ago

How many years have you (or did you) smoked?

_____ Less than 2 years

_____ 2-5 years

_____ 5-10 years

_____ 10-20 years

_____ Over 20 years

2. Have you **EVER** chewed tobacco or used snuff or other similar substances?

(If No, proceed to question 3)

☐ Yes ☐ No

Are you **STILL** using smokeless tobacco or snuff?

☐ Yes ☐ No

If No, **WHEN** did you quit?

_____ Less than 6 months ago

_____ 6 months to a year ago

_____ 1 to 3 years ago

_____ Over 3 years ago

How many years have you (or did you) used smokeless tobacco?

_____ Less than 1 year

_____ 1-2 years

_____ 2-5 years

_____ Over 5 years

3. Approximate average amount of alcoholic beverages presently consumed per week:

_____ None

_____ Less than 1 per week

_____ 1-5 drinks

_____ 6-11 drinks

_____ 11-20 drinks

_____ Over 20 drinks

4. Have you ever had a substance abuse problem?

☐ Yes ☐ No

If yes, please describe _____

5. Do you presently use any recreational drugs?

☐ Yes ☐ No

If yes, please list _____

6. Have you ever had an eating disorder?

☐ Yes ☐ No

If yes, please specify _____

7. Have you ever had any head, neck, or mouth piercings? (Other than ears)

☐ Yes ☐ No

If yes, please list _____

8. Have you ever been informed that you have been infected with an oncogenic strain (possible cancer-causing) of the Human Papilloma Virus (HPV)?

☐ Yes ☐ No

9. Please list your history or any family member's history of cancer:

10. Other concerns and considerations:

Consent--To the best of my knowledge, all of the preceding information is correct, and if there is ever any change in health or medications this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider(s) and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual until further notice. I understand there are no guarantees or warranties in health or dental care.

Signature _____
(Parent or guardian, if patient is a minor)

Date _____