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The benefits of a healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Patient Information

Patient's Name ________________________________
Title_________ I prefer to be called______________
Single   Married   Divorced   Separated   Widowed
Gender: Male Female
Birth date ____________________________________
Social Security # _______________________________
Home Address _________________________________
City _________________   State _______ Zip _________
Home phone # _________________________________
Cellular # ______________________________________
Work # ____
Email address __________________________________
Where and when are the best times to reach you?
____
Other family members seen by us _______________
Who may we thank for referring you? ____________

Responsible Party Information

Name ____
Employer Name ________________________________
Employer Address ______________________________
City______________________ State___ Zip________
Billing Address_________________________________
City __________________ State _____ Zip ___________
Home phone # _________________________________
Work #____
Cellular # ______________________________________

Emergency Contact Information

Physician______________ Phone # ______________
Emergency contact
Name ____
Relationship ___________________________________
Home ____
Cellular ____

Dental Insurance

Primary Dental Insurance

Insurance Carrier________________________________
Address ____
City ____________________State _______ Zip _______
Insurance Carrier phone # ______________________
Policy Holder's Name ___________________________
Insured's Birth Date ____________________________
Group #/ Policy # ______________________________
Contract #/ ID # _______________________________
Social Security # _______________________________
Insured's Employer _____________________________
Relationship to Patient__________________________

Secondary Dental Insurance

Insurance Carrier________________________________
Address ____
City ____________________State _______ Zip _______
Insurance Carrier phone # ______________________
Policy Holder's Name ___________________________
Insured's Birth Date ____________________________
Group #/ Policy # ______________________________
Contract #/ ID # _______________________________
Social Security # _______________________________
Insured's Employer _____________________________
Relationship to Patient__________________________

New Patient Dental History

Previous/Present Dentist _______________________
Address ____
City ___________________State _______ Zip ________
Phone_______________ Fax______________________
Email address_____________________________________
Date of last dental cleaning_____________________
Date of last Full Mouth X-Rays__________________
Date of last Bite Wing X-Rays__________________

Medical History

Your current physical health is Good Fair Poor

Are you currently under the care of a physician? **Y N**

Please explain ____

____

Are you taking aspirin? **Y N** If so, what is the dosage? ____

Are you taking any osteoporosis/bone medications? **Y N** If so, what medication and dosage? _____________________

Have you ever been told to take an antibiotic before dental work? **Y N** Please explain ___________________________

____

Please list any other prescription, over the counter drugs, vitamins, minerals and homeopathic remedies

____

____

____

Please circle YES or NO

Y N Heart Attack

Y N Heart Murmur

Y N Mitral Valve Prolapse

Y N Heart Surgery

Y N Artificial Valves

Y N Congenital Heart Defect

Y N Rheumatic Fever

Y N Pacemaker

Y N Stroke

Y N High Blood Pressure

Y N Low Blood Pressure

Y N Tuberculosis

Y N Cancer Please explain

____

Y N Chemotherapy

Y N Radiation Treatment

Y N Artificial Bones or Joints

Y N Kidney Disease

Y N Diabetes

Y N Liver Disease

Y N Hepatitis A B C

Y N Epilepsy/Seizures

Y N Hemophilia

Y N Ulcers or Colitis

Y N Psychiatric Care

Y N Difficulty Breathing/Asthma

Y N Emphysema

Y N Anemia

Y N Fever Blisters

Y N Human Papilloma Virus/HPV

Y N HIV/AIDS

Y N Venereal Disease

Y N Drug or Alcohol Abuse

Y N Severe Headaches

Y N Fainting Spells

Y N Sinus Troubles

Have you ever been hospitalized for any reason? Please explain ____

Any serious medical conditions or items not asked that may pertain to your care? **Y N** _________________________

Do you smoke? **Y N** If yes for how long? _________________ How many packs per day? _____________________

Are you allergic to any of the following?

Y N Penicillin

Y N Sulfa

Y N Erythromycin

Y N Aspirin

Y N Codeine

Y N Tetracycline

Y N Latex

Y N Dental Anesthetics

Y N Nickel/Jewelry

Please list any other drug/food/environmental allergies ____

Women Are you on birth control? **Y N** ________ Are you pregnant? **Y N week #** ___ Are you nursing? **Y N**

If you are a new patient to our office today please complete this dental history.

Why have you come to the dentist today? ____

Your current dental health is: **Good Fair Poor**

Are you currently in pain? **Y N** What alleviates your pain? ____

Have you ever had any serious/difficult problems associated with dental work? **Y N**_____________________________

Do you now or have you ever experienced pain/discomfort in your jaw or joint? (TMJ/TMD) **Y N**___________________

Do your gums bleed? **Y N** How many times a week do you floss? ____

How many times a day do you brush? ____________ What type of bristles do you use? __________________________

Office Notes/Medical Updates ____

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I understand the information that I have given today is correct to the best of my knowledge. I also understand that, this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in medical status. I authorize the dental staff to perform, with my informed consent any necessary dental services I may need during diagnosis and treatment. I authorize payment of insurance benefits to the doctor, unless I have paid my account in full. I am responsible for any fees not covered by insurance, or for any co-payment. **Payment is due in full at the time services are rendered.**

Thank you for filling this form out completely. It will enable us to help you more effectively. If you have any questions at any time just please ask us. We are happy to help. Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

Signature____ **Date** ______________________