



To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

Welcome

Date _____	
Name _____	Patient Number _____
SS#/SIN _____	Birthdate _____ Home Phone _____
Address _____	City _____ State/Prov. _____ Zip/PC _____
Email _____	Cell Phone _____
Check Appropriate Box: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
If Student, Name of School/ College _____ City _____ State/Prov _____ <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	
Patient or Parent/Guardian's Employer _____	Work Phone _____
Business Address _____	City _____ State/Prov _____ Zip/PC _____
Spouse or Parent/Guardian's Name _____	Employer _____ Work Phone _____
Whom May We Thank for Referring You? _____	
Person to Contact in Case of Emergency _____ Phone _____	
Name of Person Responsible for this Account _____ Relationship to Patient _____	
Home Phone _____ Cell Phone _____	
SS#/SIN _____	
Is this Person Currently a Patient in our Office? <input type="checkbox"/> Yes <input type="checkbox"/> No	
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.	
<input type="checkbox"/> Cash <input type="checkbox"/> Personal Check <input type="checkbox"/> Credit Card <input type="checkbox"/> I wish to discuss the office's payment policy.	
Name of Insured _____ Relationship to Patient _____	
Birthdate _____ SS#/SIN _____	
Insurance Company _____ Group# _____ Policy//ID# _____	
Do You Have Any Additional Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Complete the Following	
Name of Insured _____ Relationship to Patient _____	
Birthdate _____ SS#/SIN _____	
Insurance Company _____ Group# _____ Policy//ID# _____	

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

<p>1. Are you under medical treatment now? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain _____</p> <p>3. Are you taking any medications(s) including non-prescription medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what medications(s) are you taking? _____</p> <p>4. Have you ever taken Fen-Phen/Redux? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Do you use controlled substances? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Are you wearing contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Do you have or have you had any of the following?</p> <table border="0"> <tr> <td>High Blood Pressure</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Heart Disease</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Chest Pains</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Heart Attack</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Cardiac Pacemaker</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Easily Winded</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Rheumatic Fever</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Heart Murmur</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Stroke</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Swollen Ankles</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Angina</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Hay Fever/Allergies</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Fainting/Seizures</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Frequently Tired</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Tuberculosis</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Asthma</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Anemia</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Radiation Therapy</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Low Blood Pressure</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Emphysema</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Glaucoma</td> <td><input type="checkbox"/> Yes <input 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Are you allergic to or have you had any reactions to the following? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Local Anesthetics (e.g. Novocain) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Penicillin or any other Antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sulfa Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Barbiturate <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sedatives <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Iodine <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any Metals (e.g. nickel, mercury, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Latex Rubber <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Women Only:</p> <p>Are you pregnant or think you may be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you taking oral contraceptives? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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Patient Dental History

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

<p>1. Do your gums bleed while brushing or flossing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Are your teeth sensitive to hot or cold liquids/foods? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are your teeth sensitive to sweet or sour liquids/foods? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Do you feel pain to any of your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you have any sores or lumps in or near your mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you had any head, neck or jaw injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Have you ever experienced any of the following?</p> <table border="0"> <tr> <td>Problems in your jaw</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>8. Do you have frequent headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Clicking</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>9. Do you clench or grind your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Pain (joint, ear, side of face)</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>10. Do you bite your lips or cheeks frequently? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Difficulty in opening or closing</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>11. Have you ever had any difficult extractions in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Difficulty in chewing</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>12. Have you ever had any prolonged bleeding following extractions? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>	Problems in your jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Do you have frequent headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No	Clicking	<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Do you clench or grind your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain (joint, ear, side of face)	<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Do you bite your lips or cheeks frequently? <input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty in opening or closing	<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Have you ever had any difficult extractions in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty in chewing	<input type="checkbox"/> Yes <input type="checkbox"/> No	12. Have you ever had any prolonged bleeding following extractions? <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>13. Have you had any orthodontic treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Do you wear dentures or partials? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of placement _____</p> <p>15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Do you like your smile? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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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 my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payments of all services rendered on my behalf or my dependents.

X _____
Signature of patient (or parent/guardian if minor)

Doctor's Comments _____

Signature _____ Date _____