



### PATIENT INFORMATION (CONFIDENTIAL)

Name \_\_\_\_\_ Date \_\_\_\_\_ Patient Number \_\_\_\_\_  
 SS#/SIN \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_  
 ZIP/P.C. \_\_\_\_\_ Email \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Check Appropriate Box:  Minor  Single  Married  Separated  Divorced  Widowed  
 If Student, Name of School/College \_\_\_\_\_  Full Time  Part Time  
 City \_\_\_\_\_ State/Prov. \_\_\_\_\_  
 Patient or Parent/Guardian's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Business Address \_\_\_\_\_ 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 \_\_\_\_\_  
 Employer Address \_\_\_\_\_ 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

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_  
 SS#/SIN \_\_\_\_\_ Date Employed \_\_\_\_\_  
 Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Employer Address \_\_\_\_\_ 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 \_\_\_\_\_

## PATIENT MEDICAL HISTORY

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

1. Are you under medical treatment now?  Yes  No
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?  Yes  No
5. Do you use tobacco?  Yes  No
6. Do you use controlled substances?  Yes  No
7. Are you wearing contact lenses?  Yes  No
8. Do you have or have you had any of the following?  
 Yes  No

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

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

## PATIENT DENTAL HISTORY

Name of Previous Dentist \_\_\_\_\_ Date of Last Exam \_\_\_\_\_  
 Previous Dentist's Location \_\_\_\_\_ Date of Last Cleaning \_\_\_\_\_

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

### 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)

DOCTOR'S COMMENTS \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE