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PATIENT INFORMATION

Welcome to our office! Please fill out this form completely in ink. All information is kept confidential. If you have any questions or need assistance, please ask us - we will be happy to help.

Today's Date: _____

Title: Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Email Address: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Sex: _____ Age: _____ Birth Date: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Address: _____

If full time student, name of school: _____

Name of Spouse (parent if minor): _____

Person Responsible for Account: _____

How did you find us? _____

Additional Comments: _____

EMERGENCY INFORMATION _____
Name, Address, & Telephone of _____
a Relative not living with you _____

INSURANCE INFORMATION

PRIMARY CARRIER

Insured's Name: _____
Insurance Company: _____
Insurance Co. Address: _____
Insured's Employer: _____
Insured's
ID#: _____ Group # _____ Local# _____

SECONDARY CARRIER

If you have double insurance coverage complete this part.

Insured's Name: _____
Insurance Company: _____
Insurance Co. Address: _____
Insured's Employer: _____
Insured's
ID#: _____ Group # _____ Local# _____

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize my doctor to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to my doctor. I permit a copy of this authorization to be used in place of the original.

Patient Signature: _____ Date: _____

DENTAL HISTORY AND CONCERNS

Last Dental Visit:_____ Previous Dentist:_____

Was the treatment completed? Y ☐ N ☐ How often do you visit a dentist? Regularly ☐ Occasionally ☐ As Needed ☐

Brushing Frequency: Once Daily ☐ Twice Daily ☐ After Every Meal ☐ Do you Floss? Yes ☐ No ☐

Dental Concerns: Check All That Apply

Teeth:

- ☐ Broken or Chipped
- ☐ Crooked
- ☐ Decay
- ☐ Difficulty Chewing
- ☐ Discolored
- ☐ Loose/ Missing Filling
- ☐ Loose Teeth
- ☐ Tooth Pain
- ☐ Food Trap Areas
- ☐ Grinding or Clenching
- ☐ Missing Teeth
- ☐ Mouth Sores
- ☐ Sensitive to Cold
- ☐ Sensitive to Heat
- ☐ Sensitive to Bite
- ☐ Sensitive to Sweets

Gums:

- ☐ Bad Breath
- ☐ Red (discolored)
- ☐ Abscessed
- ☐ Bleeding
- ☐ Sore
- ☐ Swollen
- ☐ Receding

Facial/Jaw Pain:

- ☐ Frequent Headaches
- ☐ Avoid Certain Foods
- ☐ Popping/ Clicking
- ☐ Pain In Temples
- ☐ Jaw Locks Open/ Closed
- ☐ Pain In Jaw

Other Concerns:

- ☐ Smoking/ Dipping
- ☐ Biting Cheeks
- ☐ TMJ
- ☐ Tooth-Colored Fillings
- ☐ Wisdom Teeth
- ☐ Nail Biting
- ☐ Sleep Apnea
- ☐ Night Guard
- ☐ Limited Orthodontics
- ☐ Burning Tongue
- ☐ Orthodontic Treatment
- ☐ Whitening Teeth
- ☐ Tooth Replacement
- ☐ Fractured Tooth Syndrome
- ☐ Mouth Breathing
- ☐ CPAP
- ☐ Implants, tooth # _____
- ☐ Stain
- ☐ Chew On One Side
- ☐ Snoring
- ☐ Teeth Straightening
- ☐ Retainer
- ☐ Dry Mouth
- ☐ Wisdom Teeth Extraction
- ☐ Cosmetics
- ☐ Smile Makeover
- ☐ Dental Phobias

MEDICAL HISTORY

How is your general health? Good ☐ Fair ☐ Poor ☐

Are you currently under any treatment? Yes ☐ No ☐ If yes, please specify. _____

Have You Ever Had,

- ☐ Arthritis
- ☐ Arteriosclerosis
- ☐ Birth Defects
- ☐ Cancer
- ☐ Emotional Problems
- ☐ Head or Face Injury
- ☐ Heart Murmur/Trouble
- ☐ History of Substance Abuse
- ☐ Kidney Problems
- ☐ Numbness of Arms or Hands
- ☐ Swollen, Stiff, Painful Joints
- ☐ Allergies
- ☐ Asthma
- ☐ Blood Disease
- ☐ Diabetes
- ☐ Endocrine Problems
- ☐ Intestinal Disorders
- ☐ Hepatitis
- ☐ Hypertension (high blood pressure)
- ☐ Liver Problems
- ☐ Pneumonia
- ☐ Shortness of Breath
- ☐ Anemia
- ☐ Auto-Immune Disorders
- ☐ Bruise Easily
- ☐ Dizziness
- ☐ Epilepsy I Fainting
- ☐ Hearing Disorders
- ☐ High or Low Blood Sugar
- ☐ Hypotension (low blood pressure)
- ☐ Nervous Disorder
- ☐ Rheumatic Fever

MEDICAL HISTORY (CONTINUED)

Do you have any other medical conditions that we should be aware of?_____

_____

_____

Who is your current Physician?_____

(If female) are you currently: Pregnant If so when is your Due Date?_____ Nursing On Birth Control

Please List All Prescriptions

1. _____
2. _____
3. _____
4. _____
5. _____

Have you had an adverse reaction or allergies to any medication or substance?

☐ Aspirin	☐ Codeine	☐ Erythromycin
☐ Iodine	☐ Latex	☐ Nitrous Oxide
☐ Novocaine	☐ Penicillin	☐ Sulfa Drugs
☐ Tetracycline	☐ Valium	☐ Xylocaine

Other _____

All of the above information is correct to the best of my knowledge.

Patient Signature: _____ Date: _____