WELCOME

We are pleased to welcome you and/or your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

DENTAL INSURANCE

Subscriber's Name _____

Relationship to Patient _____

Birthdate _____ SS# _____

Insurance Co. _____

Group # _____ Phone (_____) _____

Is patient covered by secondary insurance? ☐ Yes ☐ No

Subscriber's Name _____

Relationship to Patient _____

Birthdate _____ SS# _____

Insurance Co. _____

Group # _____ Phone (_____) _____

PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext____ Cell (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____ Ext____ Cell Phone (_____) _____

DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

How often do you floss? _____

How often do you brush? _____

Do you wear contact lenses? ☐ Yes ☐ No

Please check (☑) "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No	Jaw pain or tiredness	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Lip or cheek biting	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Loose teeth or broken fillings	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No	Mouth pain	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
Foreign objects in mouth	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No	Sores or growths in mouth	☐ Yes	☐ No

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Phone (_____) _____ Pharmacy _____ Phone (_____) _____

Please check (☑) "yes" or "no" to indicate if you have had any of the following:

AIDS	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	HIV Positive	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No		
Chemical Dependency	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	**Have you ever had or been diagnosed with:**	
Chemotherapy	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No		
Circulatory Problems	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Artificial Heart Valves	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No	Artificial Joints, Screws, Pins, etc.	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No		
Diabetes	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No	Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No	Blood Disease	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No	Congenital Heart Lesions	☐ Yes ☐ No
Fainting or dizziness	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Special Diet/Weight Loss	☐ Yes ☐ No	Hernia Repair	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Heart Problems	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Hepatitis Type _____	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Herpes	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No		

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please describe _____

_____

Have you ever been hospitalized or do you have any other health concerns? ☐ Yes ☐ No

If yes, please describe _____

_____

Women: Are you pregnant? ☐ Yes ☐ No

Due date _____

Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Have you ever taken any of these medications?

Blood Thinners	☐ Yes ☐ No	Diet Medications	☐ Yes ☐ No
Coumadin	☐ Yes ☐ No	Dexfenfluramine	☐ Yes ☐ No
Warfarin	☐ Yes ☐ No	Fen-phen	☐ Yes ☐ No
Pondimin	☐ Yes ☐ No	Redux	☐ Yes ☐ No
Levoxyl	☐ Yes ☐ No	Synthroid	☐ Yes ☐ No

Are you allergic to:

Aspirin	☐ Yes ☐ No	Codeine	☐ Yes ☐ No
Barbiturates	☐ Yes ☐ No	Ibuprofen	☐ Yes ☐ No
Latex	☐ Yes ☐ No	Local Anesthesia	☐ Yes ☐ No
Metals (i.e. gold)	☐ Yes ☐ No	Penicillin	☐ Yes ☐ No

Other _____

Please PRINT all medications now taking: _____

_____

SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Insurance Assignment: I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company(ies)) and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Authorization to Release Protected Health Information: I understand that there may be a need to consult with other health care providers. I voluntarily authorize

Dr. _____ (Name of Doctor Disclosing PHI) to use and/or disclose my Protected Health Information (PHI) related to _____ (Describe in detail the Protected Health Information you are authorizing to be used and/or disclosed.). The information will be used and/or disclosed for the purpose of _____ (Describe each purpose for which you are authorizing your Protected Health Information to be used and/or disclosed.). I authorize Dr. _____ (Name of Doctor Receiving PHI) to receive and use the information.

This authorization will end when my current treatment plan is completed or one year from the date signed below. I understand that once the information is released it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization at any time by notifying, in writing, the above-named doctor disclosing the PHI. However, if I do revoke this authorization, it will not have any effect on any actions taken by the above-named doctor disclosing the PHI prior to their receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization. I understand I may refuse to sign this authorization.

_____ Signature of Patient, Parent, Guardian or Personal Representative

_____ Date

_____ Please print name of Patient, Parent, Guardian or Personal Representative

_____ Relationship to Patient

DOCTOR'S COMMENTS & UPDATE

(to be completed by the dentist)

Medical Clearance Letter Sent to _____ Date _____

Results _____

Signature _____ Date _____