Name (Last, First, Middle): _____ Title: _____
Home Address: _____
Preferred Name: _____ SS#: ____ - ____ - ____ DOB: ____/____/____
Home Phone: _____ Work Phone: _____ Marital: S/M/D/W Sex: M/F
How did you hear about our office?: _____
Are any other family members patients of this office? Name: _____ Relationship: _____
Who is responsible for payment of this account?: _____

PRIMARY DENTAL INSURANCE COVERAGE

Subscriber Name: _____ Relationship to patient: _____
Address: _____
SS#: ____ - ____ - ____ Employer: _____
DOB: ____/____/____ Address: _____
Plan Name: _____ Group#: _____
Insurance Co: _____
Address: _____ P hone #: _____

SECONDARY DENTAL INSURANCE COVERAGE

Subscriber Name: _____ Relationship to patient: _____
Address: _____
SS# ____ - ____ - ____ Employer: _____
DOB: ____/____/____ Address: _____
Plan Name: _____ Group#: _____
Insurance Co: _____
Address: _____ Phone #: _____

PATIENT TREATMENT CONSENT

*I authorize the Dentist(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me.

*I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist(s). This form also authorizes this Practice to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE." I authorize my Dentist(s) to release treatment records/ x-rays or any other information deemed pertinent to my insurance carrier as necessary and/or requested.

*I agree to be responsible for payment of all services rendered on my behalf or my dependents.

*Balances unpaid after 30 days are subject to a finance fee of 1.5% per month.

Preferred method of payment:

- ☐ Payment in full by cash/check
- ☐ Payment in full by VISA/MC

Patient/Parent or Guardian Signature: _____

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PATIENT INFORMATION

Name: _____ **Date of Birth:** _____ **Date:** _____
(LAST) (FIRST) (MIDDLE)

What is the reason for this appointment? _____

Are there any specific dental problems we should be aware of? _____

How long has it been since your last dental visit? _____

What was done at that time? _____

Name of your previous dentist? _____

When was your last full mouth X-rays or panorex? _____

How do you feel in general about your smile? _____

How would you describe your dental health? ☐ excellent ☐ good ☐ fair ☐ poor

How often do you brush your teeth? _____ When do you brush? _____

Do you use dental floss? _____ How Often? _____

Do you think you have any cavities? _____

Please check yes or no to the following questions:	**YES**	**NO**
Are you unhappy with the appearance of your teeth?	☐	☐
Do your gums bleed easily when you brush or floss?	☐	☐
Do you feel your breath is offensive at times?	☐	☐
Have you experienced any pain or soreness in the muscles in your face or around your ear?	☐	☐
Do you have any jaw joint cracking or pain?	☐	☐
Are your teeth sensitive to cold, heat, sweets or pressure?	☐	☐
Do you have any areas of food impaction?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you have any swellings or lumps in your mouth?	☐	☐
Have you ever had an unfavorable dental experience?	☐	☐
Have you ever had any complications from an extraction?	☐	☐
Have you ever had gum treatments?	☐	☐
Have you ever had orthodontic treatment?	☐	☐
Have you lost any teeth or had any removed?	☐	☐
Have you ever had prolonged bleeding from an extraction?	☐	☐
Have your missing teeth been replaced?	☐	☐
Are you happy with the replacement(s)?	☐	☐
Do you have any questions or concerns?	☐	☐

_____ _____
PATIENT/LEGAL GUARDIAN DATE

_____ _____
DENTIST DATE

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DENTAL HISTORY

Name:_____ **Date of Birth:**_____ **Date:**_____
(LAST) (FIRST) (MIDDLE)

Information that you may feel insignificant could actually be related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all questions.

Do you have or have you ever been treated for:	YES	NO
Any Heart Problems	☐	☐
Heart Attack	☐	☐
Angina	☐	☐
Bypass	☐	☐
Pacemaker	☐	☐
Stroke	☐	☐
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Heart Murmur*	☐	☐
Mitral Valve Prolapse*	☐	☐
Heart Valve Defect*	☐	☐
Heart Valve Replacement*	☐	☐
Rheumatic Fever*	☐	☐
Artificial Joints (Hip/Knee)*	☐	☐
Any Blood Disorders	☐	☐
Anemia	☐	☐
Hemophilia	☐	☐
Sickle Cell Trait	☐	☐
Blood Transfusions	☐	☐
Allergic Reaction to (Hives/Swelling)		
Latex (Gloves)	☐	☐
Penicillin	☐	☐
Erythromycin	☐	☐
Sulfa	☐	☐
Codeine	☐	☐
Aspirin	☐	☐
Local Anesthetic (Novocaine)	☐	☐

	YES	NO
Do you smoke?	☐	☐
Lung/Breathing Problems	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Tuberculosis	☐	☐
Sinus Trouble	☐	☐
Diabetes	☐	☐
Difficulty in Healing	☐	☐
Liver Problems/Dysfunction	☐	☐
Hepatitis/Jaundice	☐	☐
Kidney Problems/Dysfunction	☐	☐
Stomach Trouble/Ulcers	☐	☐
Alcoholism	☐	☐
Drug Abuse	☐	☐
Nervous or Mental Disorder	☐	☐
Epilepsy or Seizures	☐	☐
Thyroid Problems	☐	☐
Adrenal/Pituitary Problems	☐	☐
Sexually Transmitted Diseases	☐	☐
Other Infectious Diseases	☐	☐
HIV/AIDS	☐	☐
Cancer/Tumor	☐	☐
Other Growths	☐	☐
Chemotherapy/Radiation Therapy	☐	☐
Are you pregnant?	☐	☐

Are you aware of being allergic to any other medications or substances? Please list:_____

Do you take antibiotic pre-medication prior to dental appointments? ☐ Yes ☐ No ☐ Don't Know Name of Antibiotic:_____

Are you currently treated by a physician? ☐ Yes ☐ No Why?_____

Physician's name, address & phone #:_____

Are you presently taking any medications, pills or tonics? ☐ Yes ☐ No List:_____ For:_____
(i.e., Blood Pressure, Birth Control, Steroids, Hormones) _____ For:_____

Is there any condition or problem relating to your medical history that has not been mentioned? ☐ Yes ☐ No Explain:_____

DATE	INTERVIEWER NOTES

Pre-medication Recommended ☐ Yes ☐ No
Reason:_____ Rx:_____
Medical Alert Recommended ☐ Yes ☐ No
1.) _____
2.) _____
3.) _____

MEDICAL HISTORY REVIEW & UPDATES					
DATE	NO CHANGE	CHANGE	LIST CHANGE:	PATIENT/GUARDIAN SIGNATURE	DOCTOR/HYGIENIST SIGNATURE
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			

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MEDICAL HISTORY