Welcome

Witness Initial: ____

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible care. To help us meet all your dental needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Date ***Dr.'s Signature***

PATIENT INFORMATION (Confidential)

Name:________________________ **Birth Date:**____________ **Social Security#:**________________

Home Phone:______________ **Cell Phone:**______________ **Work Phone:**______________ Ext______

E-mail: ________________________ **Best Way To Contact You:** Cell ☐ Work ☐ Home ☐ Text ☐ Email ☐

Best Time to Contact You (Day & Time): ________________________________

Available Appointment Time (Day & Time): ________________________________

Address: ________________________ **Apt**.________ City: ____________ State: _______ Zip Code: __________

Gender: M ☐ **F** ☐ **Other** ☐ **Check Appropriate Box:** Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other ☐

Name of Emergency Contact Person: ________________________________

Phone # of Emergency Contact Person:________________________ Relationship to Patient:______________

If Patient is a Student, Name of School/College: ________________________ Full Time ☐ Part Time ☐

Who/What Referred You Here: ________________________________

RESPONSIBLE PARTY

Name of Person Responsible for this Account: ________________________ Birth Date: ______________

Relationship to Patient: ______________ Is the Responsible Party Currently a Patient in our Office? Yes ☐ NO ☐

Address: ________________________ **Apt.**________ City: ____________ State: _______ Zip Code: __________

Responsible Person Signature: ________________________ **Date:**______________

I acknowledge that I am responsible for everything on this account, including financial balance.

INSURANCE INFORMATION (If you already gave us the insurance information, no need to fill out).

---------------------Primary Dental Insurance----------------------

Name of Insurance Company: ______________ SS# or Member ID#: ______________ Group #: __________

Name of Insured: ________________________ Birth Date of Insured: ____________ Relationship to Patient: __________

Address of Ins: ________________________ City:______________ State: ______ Zip Code: __________

---------------------Secondary Dental Insurance---------------------

Name of Insurance Company: ______________ SS# or Member ID#: ______________ Group #: __________

Name of Insured: ________________________ Birth Date of Insured: ____________ Relationship to Patient:__________

Address of Ins: ________________________ City:______________ State: ______ Zip Code: __________

PATIENT DENTAL HISTORY

Date of Last Dental Visit: ______________________

Do Your gums bleed while brushing or flossing? Yes ☐ NO ☐
Are your teeth sensitive to hot/cold liquids/ food? Yes ☐ NO ☐
Are your teeth sensitive to sweet/sour liquids/ food? Yes ☐ NO ☐
Do you feel pain in any of your teeth? Yes ☐ NO ☐
Do you have any sores or lumps in or near your mouth? Yes ☐ NO ☐
Have you had any head, neck or jaw injuries? Yes ☐ NO ☐
Have you ever experienced any of the following problems in your jaw? Yes ☐ NO ☐
a). Clicking? Yes ☐ NO ☐
b). Pain (joint, ear, side of face)? Yes ☐ NO ☐
c). Difficulty in opening or closing? Yes ☐ NO ☐
d). Difficulty in chewing? Yes ☐ NO ☐
Have you ever had instructions on the care of your gums? Yes ☐ NO ☐

Reason for this visit:______________________

Do you have frequent headaches? Yes ☐ NO ☐
Do you clench or grind your teeth? Yes ☐ NO ☐
Do you bite your lips or cheeks frequently? Yes ☐ NO ☐
Have you ever had any difficult extractions in the past? Yes ☐ NO ☐
Have you ever had braces? Yes ☐ NO ☐
Have you ever had instruction on the correct method of brushing your teeth? Yes ☐ NO ☐
*What cosmetic concerns do you have that you would like to have corrected?______________________

____

____

MEDICAL HISTORY

Doctor Initial: _____

Are you allergic to or have you had any reactions to the following? Please check those that apply:

Local Anesthesia (e.g. Lidocaine):	**Yes**	**No**
Penicillin:	**Yes**	**No**
Sulfa Drugs:	**Yes**	**No**
Barbiturates:	**Yes**	**No**
Sedatives:	**Yes**	**No**
Iodine:	**Yes**	**No**
Aspirin:	**Yes**	**No**
Codeine:	☐ **Yes**	☐ **No**
Latex:	**Yes**	**No**
Other *(please list)*: ____________________________	**Yes**	**No**

____

I have no known allergies ☐

Women Only:

Are you pregnant or think you may be pregnant?	**Yes**	**No**
Are you nursing?	**Yes**	**No**
Are you taking birth control pills?	**Yes**	**No**

Have you ever had any of the following? Please check those that apply: ☐ **I have no known *Medical Condition***

☐ AIDS	☐ Excessive Bleeding	☐ Kidney Disease	☐ Stroke
☐ Allergies _______________	☐ Fainting	☐ Liver Disease	☐ Thyroid Condition
☐ Anemia	☐ Glaucoma	☐ Mental Disorders	☐ Tuberculosis
☐ Arthritis	☐ Growths	☐ Nervous Disorders	☐ Tumors
☐ Artificial Joints	☐ Hay Fever	☐ Pacemaker	☐ Ulcers
☐ Asthma	☐ Head Injuries	☐ Radiation Treatment	☐ Venereal Disease
☐ Blood Disease/Condition	☐ Heart Disease/Condition	☐ Respiratory Problems	☐ Cholesterol
☐ Cancer: Type ____________	☐ Heart Murmur	☐ Rheumatic Fever	☐ Jaundice
☐ Diabetes	☐ Hepatitis: Type __________	☐ Rheumatism	OTHER:
☐ Dizziness	☐ High Blood Pressure	☐ Sinus Problems	☐ _______________________
☐ Epilepsy	☐ Low Blood Pressure	☐ Stomach Problems	☐ _______________________

Please list *medications* you are currently taking: or Not Taking any MEDICATION ☐

1. Name: ________________________	Dosage: ________________	**2.** Name: ________________________	Dosage: ________________
3. Name: ________________________	Dosage: ________________	**4.** Name: ________________________	Dosage: ________________
5. Name: ________________________	Dosage: ________________	**6.** Name: ________________________	Dosage: ________________
7. Name: ________________________	Dosage: ________________	**8.** Name: ________________________	Dosage: ________________
9. Name: ________________________	Dosage: ________________	**10.** Name: ________________________	Dosage: ________________

SLEEP HISTORY

Do you snore or have been told you snore?	Yes	No
Have you been told you stop breathing or gasp during sleep?	Yes	No
Do you feel groggy or unrefreshed in the morning?	Yes	No
Are you often fatigued during your day?	Yes	No
Do you fall asleep sitting, reading, watching TV or driving?	Yes	No
Have you been told that you grind your teeth during sleep?	Yes	No
Have you ever had a sleep study?	Yes	No
Do you have Obstructive Sleep Apnea or suspect you have OSA?	Yes	No
Are you currently being treated for OSA or another sleep disorder?	Yes	No

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

  If yes, please explain: ____

- Are you now under the care of a physician? ☐ Yes ☐ No

  If yes, please explain: ____

- Name of Physician: ________________________________ Phone: ____________________

- Have you ever had any surgeries? ☐ Yes ☐ No

  If yes, please list the surgeries and the date they were performed: ______________________________

  ____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐Yes ☐ No

  If yes, please explain: ____

- Do you have any health problems that need further clarification? ☐ Yes ☐ No

  If yes, please explain: ____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor(s) at the next appointment without failure.

____ ____________________

Print Name and Sign Date