



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

**Patient Information** (CONFIDENTIAL)

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Patient # \_\_\_\_\_  
 SS#/SIN \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov \_\_\_\_\_  
 Zip/ P.C. \_\_\_\_\_  
 Email \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Check Appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated  
 If Student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State/Prov

**Full Time Part Time**

Patient or Parent/Guardian's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Business Address \_\_\_\_\_ City \_\_\_\_\_ 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 \_\_\_\_\_  
 Address of Employer \_\_\_\_\_ City \_\_\_\_\_ Estate/ Prov. \_\_\_\_\_  
 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 **IF YES, COMPLETE THE FOLLOWING:**

Name of Insured \_\_\_\_\_ Relationship to \_\_\_\_\_

# Patient

Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ Estate/ Prov. \_\_\_\_\_

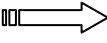
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ ID# \_\_\_\_\_

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 \_\_\_\_\_ **Over Please!** 

1. Are you under medical treatment now?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Are you allergic to or have you had any reactions to the following.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?.. If yes, please explain _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Local Anesthetics (e.g. Novocain).....	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you taking any medication(s) including non-prescription medicine?..... If yes, what medication(s) are you taking? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Penicillin or any other Antibiotics .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you ever taken Fen-Phen/Redux?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sulfa Drugs .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you use tobacco?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Barbiturates.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Do you use controlled substances?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sedatives.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Are you wearing contact lenses?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Iodine .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Do you have or have you had any of the following?  <input type="checkbox"/> High Blood Pressure..... <input type="checkbox"/> Heart Attack..... <input type="checkbox"/> Rheumatic Fever..... <input type="checkbox"/> Swollen Ankles..... <input type="checkbox"/> Fainting/Seizures..... <input type="checkbox"/> Asthma..... <input type="checkbox"/> Low Blood Pressure..... <input type="checkbox"/> Epilepsy/Convulsions..... <input type="checkbox"/> Leukemia..... <input type="checkbox"/> Diabetes..... <input type="checkbox"/> Kidney Diseases..... <input type="checkbox"/> Thyroid Problem .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Aspirin .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Any Metals (e.g. nickel, mercury, etc.).....	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Latex Rubber.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Other (please list) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
		10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)..	<input type="checkbox"/> Yes <input type="checkbox"/> No
		11. Women Only:	<input type="checkbox"/> Yes <input type="checkbox"/> No
		a) Are you pregnant or think you may be pregnant?...	<input type="checkbox"/> Yes <input type="checkbox"/> No
		b) Are you nursing?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
		c) Are you taking oral contraceptives?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Chest Pains.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Easily Winded.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Stroke.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Hay Fever/Allergies.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Tuberculosis.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Radiation Therapy.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Glaucoma.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Recent Weight Loss.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Liver Disease.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Heart Trouble.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Respiratory Problems.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Mitral Valve Prolapse.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Other.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Heart Disease.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Cardiac Pacemaker.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Heart Murmur.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Angina.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Frequently Tired.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Anemia.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Emphysema.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Cancer.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Arthritis.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Joint Replacement or Implant.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Hepatitis/Jaundice.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Sexually Transmitted Disease.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Stomach Troubles/Ulcers.....	<input type="checkbox"/> Yes <input type="checkbox"/> No

## Patient Dental History

Name of Previous Dentist and Location \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

1. Do your gums bleed while brushing or flossing?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	problems in your jaw?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are your teeth sensitive to hot or cold liquids/foods?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Clicking.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are your teeth sensitive to sweet or sour liquids/foods?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain (joint, ear, side of face).....	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you feel pain to any of your teeth?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty in opening or closing.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you have any sores or lumps in or near your mouth?....	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty in chewing.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you had any head, neck or jaw injuries?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Do you have frequent headaches?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you ever experienced any of the following		9. Do you clench or grind your teeth?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No

- 10. Do you bite your lips or cheeks frequently?.....
- 11. Have you ever had any difficult extractions in the past?.....
- 12. Have you ever had any prolonged bleeding following extractions?.....
- 13. Have you had any orthodontic treatment?.....
- 14. Do you wear dentures or partials?.....

- if yes, Date of placement \_\_\_\_\_
- 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?.....
  - 16. Do you like to smile?.....

## 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)*