

Patient Name: First _____ MI _____ Last _____ Preferred Name: _____

Gender: M F SSN: _____ Birth Date (mm/dd/yyyy): _____

Address: Street _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Mobile _____ Text Msg OK? Y N

E-mail: _____

Referred to us by: _____

Current Medication

Are you currently taking any blood thinners?

Yes No

What medications are you currently taking?

Name Dosage Frequency

Name Dosage Frequency

Name Dosage Frequency

Allergies

Are you allergic to any of the following?

- Adhesive Tape
- Antibiotics
- Latex
- Aspirin
- Iodine
- Codeine
- Sulfa
- Local Anesthetics

Do you have any other allergies?

Name Reaction

Name Reaction

Dental History

When was your last dental exam?

Date _____

When was your last dental x-ray taken?

Date _____

How often do you brush? How often do you floss?

times/ day _____ # times/ day _____

Do you grind your teeth?

Yes No

Have you ever had orthodontic (braces) treatment?

Yes No

Have you ever had periodontal (gum) treatments?

Yes No

Do you have any of the following?

- Bad Breath
- Dry Mouth
- Partial
- Bleeding Gums
- Difficulty Chewing
- Sensitivity to Cold
- Blisters on Mouth
- Ear Pain
- Sensitivity to Heat
- Broken Fillings
- Jaw Pain
- Sensitivity to Sweets
- Clicking Jaw
- Loose Teeth
- Sensitivity to Pressure
- Dentures
- Mouth Pain
- Swollen Gums
- Mouth Sores
- Difficulty Opening and Closing

Lifestyle Factors

Have you ever smoked?

 Yes No # of Years _____ # of Packs/ day _____

Do you smoke now?

 Yes No # of Years _____ # of Packs/ day _____

Do you use recreational drugs?

 Yes No Types? _____ # times/ week _____

How much alcohol do you drink per week?

drinks/ week _____

How much caffeine do you drink per day?

drinks/ day _____

Women Only

Are you pregnant?

 Yes No

Are you breastfeeding?

 Yes No**Past Medical History**

Have you ever had any of the following?

- | | | | | | |
|---|--|---|---|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Migraines | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Joint Disorder | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Bowel Disorder | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disorder | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Lung Disorder | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis- A, B or C | <input type="checkbox"/> Lupus | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Major Surgery |
| <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Measles | <input type="checkbox"/> Stroke | <input type="checkbox"/> Joint Replacement |

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I attest to the accuracy of the information on this page.

Patient's / Guardian's Signature
Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

[Please Print Name]

[Signature]

[Date]

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

