



Welcome To Our Office!

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient information	(Confidential)			
Name		Date		
Soc. Sec. #	Birthdate	Home Phone	Cell	#
Address	City	State	Zi	p
Email	:	Driver's License #		
When confirming appointm	nents how do you prefer to be con	ntacted? Phone	Email Text Mess	age
Patient's or Parent's Employ	yer	Work	Phone	
Business Address	City	State	Zip	
Spouse or Parent's Name _	Employer	Work	r Phone	
☐ TV ☐ Google ☐ Webs	ut our office? (Check All That A site	✓ □ Brochure		
Person to Contact in Case of	of Emergency	Phor	ne	
Responsible Party				
	le for this Account		cionship ntient	
Contact #		Birth	date	
Employer	Work Phone	SSN	#	
Is this Person Currently a P	atient in our Office? Yes No			
•	offer the following methods of pay k 🔲 Visa/Mastercard 🚨 Discove		option you prefer.	
Insurance Information	on			
Name of Insured			ionship itient	
Birthdate	Social Security #	Date	Employed	
Name of Employer	Union or	Local # Work	r Phone	
Insurance Company	Group #	Polic	y/ID #	
Ins. Co. Address	City_	State	Zip	

Patient Medical History Office Phone_ ___ Date of Last Exam ___ Physician Yes No 7. Are You Allergic to: Yes No 1. Are you under medical treatment now? Local Anesthetics (e.g. novocaine) 2. Have you ever been hospitalized for any Penicillin surgical operation or serious illness Other Antibiotics _____ within the last 5 years? Sulfa Drugs If yes, please explain ___ Sedatives Iodine 3. Are you taking any medication(s) including Aspirin non-prescription medicine? Ibuprofen If yes, what medications are you taking? __ Tylenol Codeine Any Metals (e.g. nickel, mercury, etc.) 4. Are you currently taking or have you ever taken osteoporosis medications in the past? Latex Rubber Other If so, how long?_ 8. Women Only: Which ones? a) Are you pregnant or think you may be pregnant? 5. Do you use Tobacco? b) Are you Nursing? 6. Do you use controlled substances c) Are you taking oral contraceptives or recreational drugs? 9. Do you have or have you had any of the following? Yes No Yes No No Yes High Blood Pressure Hearing Impaired Sexually Transmitted Disease Stomach Troubles / Ulcers Heart Attack Heart Disease Rheumatic Fever Mitral Valve Prolapse Vertigo Swollen Ankles Congestive Heart Failure Neck Pain $\overline{\Box}$ $\bar{\Box}$ Fainting Cardiac Pacemaker Back Pain Heart Murmur Chest Pains Seizures Low Blood Pressure Angina Easily Winded ā ā $\bar{\Box}$ ā Epilepsy / Convulsions Frequently Tired Stroke Hay Fever / Allergies Cancer Anemia Radiation Therapy Ephysema / COPD Glaucoma Tuberculosis Recent Weight Loss Diabetes ā Kidney Diseases Asthma Liver Disease AIDS or HIV Infection Arthritis Other___ Joint Replacement or Implant Thyroid Problem Sight Impaired Hepatitis / Jaundice **Patient Dental History** Name of Previous Dentist/Location _____ Date of Last Exam/Cleaning___ Yes No Yes No 1. Do your gums bleed while 8. Do you have frequent headaches? brushing or flossing? 9. Do you clench or grind your teeth? 2. Are your teeth sensitive to 10. Do you bite your lips or cheeks frequently? hot or cold liquids/foods? 11. Have you ever had any difficult extractions 3. Are your teeth sensitive to sweet or sour in the past liquids/foods? 4. Do you feel pain to any of your teeth? 12. Have you ever had any prolonged bleeding following extractions? 5. Do you have any sores or lumps in or near your mouth? 13. Have you had any orthodontic treatment? 6. Have you had any head, neck or jaw injuries? 14. Do you wear dentures or partials? 7. Have you ever experienced any of the following If yes, date of placement_ problems in your jaw? 15. Have you ever received oral hygiene Clicking instructions regarding the care of your teeth and gums? Pain (joint, ear, side of face) Difficulty in opening or closing Difficulty in chewing 16. Do you like your 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 agree to be responsible for payment of all service rendered on my behalf of my dependents.

Signature of Dationt (D.

Signature of Patient (Parent or Minor)_		
Doctor's Signature	Date	