Patient Info

Chart Number: ________________

Name: ______________________________ Date: ______________

SSN: ______________ Birthday: __________ Phone #: ______________

Address1: ______________________________ City: ______________

Address2: ______________________________ State: ______ Zip: __________

Email: ______________________________ Alt Phone #: ______________

Please Check the Appropriate Box: ☐Minor ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

If Student, Name of School/College: __________ City: __________ State: ______ ☐Full Time ☐Part Time

Patient or Parent/Guardian's Employer ____________________ Work Phone: ______________

Business Address ______________ City: __________ State: ______ Zip: __________

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: ______________________________ Alt Phone #: ______________

Driver's License #: ______________ Birthday: __________ Financial Institution: __________

Employer: ______________ Work Phone: __________ SSN: ______________

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: __________

Birthday: __________ SSN: ______________ Date Employed: ______________

Name of Employer: ______________ Union or Local #: __________ Phone: __________

Employer Address: ______________ City: __________ State: ______ Zip: ______

Insurance Company: ______________ Group #: __________ Policy/ID#: __________

Ins. Co. Address: ______________ City: __________ State: __________

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 information below

Name of Insured: ______________________________ Relationship to Patient: __________

Birthday: __________ SSN: ______________ Date Employed: ______________

Name of Employer: ______________ Union or Local #: __________ Phone: __________

Employer Address: ______________ City: __________ State: ______ Zip: ______

Insurance Company: ______________ Group #: __________ Policy/ID#: __________

Ins. Co. Address: ______________ City: __________ State: __________

How Much is Your Deductible? ______ How Much Have You Used? ______ Max. Annual Benefit: ______

Patient Medical History

Physician: ______________ Office Phone: __________ Last Exam Date: __________

	YES	NO
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain ______________		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? ______________		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐

	YES	NO
9. Are you allergic to or have you had any reactions to the following:		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury,etc.)	☐	☐
Latex Rubber	☐	☐
Other: ______________	☐	☐
10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
11. Women Only:		
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

8. Do you have or have you had any of the following?

	YES	NO		YES	NO		YES	NO
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐	Family history of diabetes	☐	☐
						Other: __________	☐	☐

Patient Dental History

Name of Previous Dentist and Location ______________ Date of Last Exam __________

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

	YES	NO
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 your smile?	☐	☐
17. Do you require antibiotics prior to dental treatment?	☐	☐
18. How many times a day do you brush? ______		
19. How many times a week do you floss? ______		
20. How much coffee/soda do you drink a day? ______		
21. Do you have any dental problems you would like to discuss with the dentist?	☐	☐

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 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)

Doctor's Comments ______________