Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet your dental healthcare 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.

Patient Information **(CONFIDENTIAL)** **SS#/SIN**_____

Name:_____Birthdate:_____ Home Phone:_____
Email: _____ Cell Phone:_____
Check appropriate box: [ ] minor [ ]Single [ ]Married [ ]Widowed
Home address: _____City:_____ State: _____
Patient or Parent/Guardian's Employer:_____ Work Phone:_____
Whom may we thank for referring you?_____

Person to contact in case of an emergency:_____
Relationship:_____Phone:_____

Responsible Party

Name of person responsible for this account:_____
Relationship to patient:_____ Address:_____
Phone #_____ Email:_____
Driver's License #_____ Birthdate:_____ Work Phone:_____
Employer:_____ SS#/SIN_____

FOR YOUR CONVENIENCE, WE OFFER THE FOLLOWING METHODS OF PAYMENT: AMEX, VISA, MASTERCARD, DISCOVER, CASH, PERSONAL CHECK AND CARE CREDIT. PAYMENT IN FULL IS EXPECTED AT EACH APPOINTMENT.

Insurance Information

Name of Insured:_____Relationship to patient:_____
Birthdate:_____ SS#/SIN_____ Work phone#_____
Name of Employer:_____City:_____State:_____
Insurance Co._____ Group #_____ Policy ID#_____
Insurance Co. Address:_____ City:_____State_____

DO YOU HAVE ADDITIONAL INSURANCE [ ] YES [ ] NO IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of Insured:_____Relationship to patient:_____
Birthdate:_____ SS#/SIN_____ Work phone#_____
Name of Employer:_____City:_____State:_____
Insurance Co._____ Group #_____ Policy ID#_____
Insurance Co. Address:_____ City:_____State_____

Authorization and Release

I certify that I have read and understand the information on this history to the best of my knowledge. The questions on this form have been answered accurately. 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 examinations 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, 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 dependants.

_____ _____
Patient/ Parent/Guardian Signature Date

DOCTOR SIGNATURE:_____ DATE REVIEWED:_____

*Physician*_____*Office Phone:*_____*Date of last exam:*_____

	Y N		Y N
1.Are you under medical treatment now?	*[ ] [ ]*	*8. Are you wearing contact lenses?*	*[ ] [ ]*
*2. Have you been hospitalized for any surgical operation or serious illness within the last 5 yrs? If yes, please explain:*_____ _____	*[ ] [ ]*	*9. Are you allergic or have you had any reactions to any of the following?* *Local Anesthetics (e.g. Novacain)* *Penicillin or any other antibiotics*	*[ ] [ ]* *[ ] [ ]* *[ ] [ ]*
*3. Are you taking any medication(s), including non-prescription medicine? if yes, please list:*_____ _____ _____ _____	*[ ] [ ]*	*Sulfa Drugs* *Barbiturates* *Sedatives* *Iodine* *Asprin*	*[ ] [ ]* *[ ] [ ]* *[ ] [ ]* *[ ] [ ]* *[ ] [ ]*
4. Have you ever taken Fosamax, Boniva, Actonel or any other cancer medications containing bisphosphonates?	*[ ] [ ]*	*Any metals? (e.g., nickel, mercury, etc.)*	*[ ] [ ]*
5. Have you taken Viagra, Revati, Cialis or Levitra in the last 24 hours?	*[ ] [ ]*	*Latex Rubber* *Other (please list)*_____	*[ ] [ ]* *[ ] [ ]*
*6. Do you use tobacco? If yes, what type, how much and for how long?*_____ _____	*[ ] [ ]*	*10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks?)*	*[ ] [ ]*
7. Do you use controlled substances?	*[ ] [ ]*	*WOMEN ONLY*	
		11. Are you pregnant or think you may be pregnant?	*[ ] [ ]*
		a) Are you nursing?	*[ ] [ ]*
DO YOU HAVE ANY OF THE FOLLOWING?		*b) Are you taking contraceptives?*	*[ ] [ ]*

	Y N		Y N		Y N
High blood pressure	*[ ] [ ]*	Heart Disease	*[ ] [ ]*	Chest Pains	*[ ] [ ]*
Rheumatic Fever	*[ ] [ ]*	Cardiac Pacemaker	*[ ] [ ]*	Easily Winded	*[ ] [ ]*
Swollen Ankles	*[ ] [ ]*	Heart Murmur	*[ ] [ ]*	Stroke	*[ ] [ ]*
Fainting Seizures	*[ ] [ ]*	Angina	*[ ] [ ]*	Hay Fever/Allergies	*[ ] [ ]*
Asthma	*[ ] [ ]*	Frequently Tired	*[ ] [ ]*	Tuberculosis	*[ ] [ ]*
Low Blood Pressure	*[ ] [ ]*	Anemia	*[ ] [ ]*	Radiation Therapy	*[ ] [ ]*
Epilepsy/Convulsions	*[ ] [ ]*	Emphysema	*[ ] [ ]*	Glaucoma	*[ ] [ ]*
Leukemia	*[ ] [ ]*	Cancer	*[ ] [ ]*	Recent Weight Loss	*[ ] [ ]*
Diabetes	*[ ] [ ]*	Arthritis	*[ ] [ ]*	Liver Disease	*[ ] [ ]*
Kidney Disease	*[ ] [ ]*	Joint Replacement Or Implant	*[ ] [ ]*	Heart Trouble	*[ ] [ ]*
AIDS or HIV infection	*[ ] [ ]*	Hepatitis/Jaundice	*[ ] [ ]*	Respiratory Problems	*[ ] [ ]*
Thyroid Problem	*[ ] [ ]*	Stomach Troubles/Ulcers	*[ ] [ ]*	Mitral Valve Prolapse	*[ ] [ ]*

Other:_____

Name of Previous Dentist & Address:_____ **Date of last exam:**_____

	Y N		Y N
1. Do your gums bleed while brushing or flossing?	*[ ] [ ]*	8. Do you have frequent headaches?	*[ ] [ ]*
2. Are your teeth sensitive to hot or cold?	*[ ] [ ]*	9. Do you clench/grind your teeth?	*[ ] [ ]*
3. Do you feel pain to any of your teeth?	*[ ] [ ]*	10. Have you ever had a difficult extraction?	*[ ] [ ]*
4. Do you have any lumps in your mouth?	*[ ] [ ]*	11. Have you ever had prolonged bleeding?	*[ ] [ ]*
5. Are your teeth sensitive to sweet or sour foods or liquids?	*[ ] [ ]*	12. Have you had braces?	*[ ] [ ]*
6. Have you had neck or jaw injuries?	*[ ] [ ]*		
7. Have you experienced any of the following problems with your jaw? Clicking Pain (joint, ear, side of face) Difficulty opening or closing Difficulty in chewing?	*[ ] [ ]* *[ ] [ ]* *[ ] [ ]* *[ ] [ ]*	13. Do you wear partials or dentures? If yes, date of placement:_____	*[ ] [ ]*