Patient Information

Name: _____ Date of birth: _____
Last First Middle

SSN:_____ Gender: _____ Height: _____ Weight: _____

for children under 18 and adults unable to consent for treatment:
Parent/guardian/medical power of attorney: _____

Preferred phone number: _(____)_____ *please circle:* Cell Home Work

Secondary phone number: _(____)_____ *please circle:* Cell Home Work

Mailing address: _____
Street City State Zip

If different from mailing address:
Home address:_____
Street City State Zip

Email Address: _____ *(Your email will only be used to confirm appointments. It will never be shared with anyone outside of this office.)*

Preferred method to contact you? *Please circle:* Phone call Text message Email

Emergency Contact: _____ Relationship:_____ Phone number: _(____)_____

Whom may we thank for referring you to our office? _____

Patient Medical History

In this section, please circle Yes or No as indicated.
Are you currently under the care of a physician? Yes No

Physician's name: _____ Physician's phone number: _____

Date of Last physical exam: _____

Have you had a serious illness, surgery, or hospitalization within the last 5 years? Yes No

If Yes, please describe: _____

Do you drink alcoholic beverages? Yes No
If yes, how much alcohol did you drink in the last 24 hours? _____
If yes, how much do you typically drink in a week? _____

Do you use tobacco products? Yes No
If yes, which products? *(please circle)* cigarettes cigars chew snuff e-cigarettes
If yes, roughly how many per week? _____
If yes, how interested are you in quitting? *(please circle)* very somewhat not interested

Do you use marijuana? Yes No
If yes, how frequently? _____

Do you use illegal substances? *(cocaine, heroine, meth, etc.)* Yes No
If yes, please describe: _____

Are you taking or scheduled to begin taking oral bisphosphonates for osteoporosis or Paget's disease?
Yes No Not sure
Have you ever been treated with or presently scheduled to begin treatment with intravenous bisphosphonates for bone pain, hypercalcemia, osteoporosis, or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer? Yes No Not sure If yes, date_____

Patient Insurance Information

Primary Insurance

Insured's Name:_____

Insurance Company:_____

Address:_____

_____

Phone:__(____)_____

ID #:_____

Group:_____

Employer:_____

SSN:_____

Secondary Insurance

Insured's Name:_____

Insurance Company:_____

Address:_____

_____

Phone:__(____)_____

ID #:_____

Group:_____

Employer:_____

SSN:_____

Insurance Agreement

I certify that the above information is correct and in force. I am aware that it is my responsibility to read and understand my own dental insurance policy, including benefits, limitations, and exclusions. I understand that although the filing of insurance claims is provided as a service to me at this office, that any agreement for dental coverage is between myself and my insurance company. I understand that services are rendered independent of insurance reimbursement.

_____ _____ _____

Signature of patient or authorized responsible party | Relationship | Date

Patient Medical History cont.

Do you take any prescription or over the counter medications or supplements? Yes No If yes, please list all. *Include vitamins, natural/herbal preparations, and diet supplements.*

_____

_____

_____

Are you allergic to or have you ever had an adverse reaction to any medications or substances? Yes No If yes, please list all. *Include foods, metals, latex, anesthetics, antibiotics, and medications.*

_____

_____

Women only:
Are you pregnant? Yes No
If yes, how many weeks pregnant? _____
Do you take birth control pills or hormone replacements? Yes No
Are you nursing? Yes No

Are you currently or have you previously been diagnosed with or treated for any of the following? *Please check all that apply.*

☐Cardiovascular disease
☐Angina
☐Congestive heart failure
☐Heart attack
☐Heart murmur
☐High blood pressure
☐Low blood pressure
☐Mitral valve prolapse
☐Atrial fibrillation or other cardiac arrhythmia
☐Arteriosclerosis
☐Stroke
☐Pacemaker
☐Rheumatic fever
☐Rheumatic heart disease
☐Artificial (prosthetic) heart valve
☐Previous infective endocarditis
☐Damaged valves in transplanted heart
☐Congenital heart disease(CHD)
☐Unrepaired cyanotic CHD
☐Repaired CHD in last 6 months
☐Repaired CHD w/residual defects
☐Anemia
☐Reflux/persistent heartburn

☐Hemophilia
☐Arthritis type: _____
☐Stomach ulcers
☐Joint replacement If yes, any complications?_____
Dates and joints replaced:_____
_____
☐Autoimmune disease, type:____
_____
☐Asthma
☐Bronchitis
☐Emphysema
☐Sinus troubles
☐Hay fever/seasonal allergies
☐Tuberculosis
☐Cough longer than 3 weeks
☐Cough that produces blood
☐Been exposed to anyone with tuberculosis
☐Cancer/chemotherapy/radiation treatment, specify: _____
☐Chronic pain
☐Diabetes ☐Type I ☐Type II
☐Eating disorder
☐Malnutrition
☐Gastrointestinal disease
☐Poor wound healing

☐Thyroid disorder, type: _____
☐Kidney disorder, type: _____
☐Glaucoma
☐Wear contact lenses
☐Jaundice or liver disease
☐Hepatitis ☐A ☐B ☐C
☐AIDS or HIV infection
☐Fainting spells or seizures
☐Vertigo
☐Dementia
☐Alzheimer's disease
☐Neurological disorder
☐Epilepsy
☐Sleep apnea
☐Mental health condition, type:____
_____
☐ Recurrent infection(s): type:_____
_____
☐Night sweats
☐Osteoporosis
☐Persistent swollen glands in neck
☐Severe headaches/migraines
☐Rapid weight gain or weight loss
☐Sexually transmitted disease
☐Blood transfusion date: _____
☐Excessive bleeding or easily bruises

Any medical conditions not mentioned above? _____

Preferred Pharmacy: _____

Patient Dental History

Patient Name: _____ Date: _____

Reason for seeking dental care at this time _____

How often do you: Brush? _____ times per _____ Floss/clean in between teeth? _____ times per _____

Is your home water supply fluoridated? ☐Yes ☐No ☐Not sure
Which toothpaste do you use? _____

How do you feel about dental treatment? ☐ Relaxed ☐A little uneasy ☐Tense ☐Anxious ☐Very Anxious

Are you currently or have you recently experienced any of the following? *Please check all that apply*

☐Aching teeth
Teeth that are sensitive to:
☐hot ☐cold ☐sweets ☐pressure
☐Missing teeth
☐Broken teeth or fillings
☐Loose teeth
☐Food traps between teeth
☐Neck pain or earaches
☐Gums that bleed with brushing/flossing
☐Sensitive or sore gums
☐Swellings or lumps in your mouth
☐Sores or ulcers in your mouth
☐Frequent dry mouth
☐Bad taste in your mouth
☐Wear partials or dentures
☐Participate in contact sports/activities
☐Wear an orthodontic appliance
☐Clicking or popping of the jaw joint
☐Pain in the jaw joint
☐Difficulty chewing
☐Difficulty opening wide
☐Teeth clenching or grinding
☐Frequently chews gum
☐Wear a night guard appliance
☐Use a CPAP

Do you have a history of any of the following? *Please check all that apply*

☐Serious injury to your head, neck, or mouth If yes, describe: _____
☐Past periodontal (gum) treatment
☐Past orthodontic (braces/retainers) treatment
☐Past difficult or complicated extraction or dental surgery
☐Cold sores
☐Other mouth sores, If yes, describe: _____
☐Head, neck, or oral cancer If yes, type and date: _____

If you could change your smile, what would you change?

☐Whiten teeth
☐Make teeth the same color
☐Remove unsightly fillings
☐ Reduce facial fine lines and wrinkles
☐ Close gaps between teeth
☐Change the shape of teeth
☐Replace missing teeth
☐Straighten teeth
☐Other _____

Consent

I, the undersigned, hereby authorize the doctors, hygienists, and assistants to take radiographs, study models, photographs, or any other diagnostic aids the doctors deem appropriate to make a thorough assessment of my dental diagnosis and treatment needs. I also authorize the doctors to perform any and all forms of treatment, medication, and therapy that may be indicated. I authorize and consent that the doctors employ any such assistance as they deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs, and records of any treatments or examinations rendered to my insurance company and consulting professionals that may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for myself and my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related collection fees. I understand that payment in full is due at the date of delivery of all crowns, bridges, partials, dentures, and implant crowns/dentures. I understand that payment in full must be made within 90 days of treatment. Any other arrangements for payment must be made before treatment begins.

_____ _____ _____

Signature of patient or authorized responsible party | Relationship | Date