

## Patient Information

*Please fill out all pages completely*

Name \_\_\_\_\_ I preferred to be called \_\_\_\_\_

M \_\_\_\_\_ F \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home address \_\_\_\_\_

*Street City State Zip*

Minor \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

***Email Address (required)*** \_\_\_\_\_

Responsible Party's name if other than patient \_\_\_\_\_

Phone \_\_\_\_\_

If a minor, parent/guardian's name \_\_\_\_\_

Phone \_\_\_\_\_

If you're a student, Name of school \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's address \_\_\_\_\_

*Street City State Zip*

Patient/Parent Employer's Phone \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Who should we contact in case of an emergency? \_\_\_\_\_

*name phone*

Other family members seen by us? \_\_\_\_\_

## Dental Insurance Information

Name of Insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Insured's Birthdate \_\_\_\_\_ Insured's SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insured's Subscriber ID # \_\_\_\_\_

Insured's Employer \_\_\_\_\_ Phone number \_\_\_\_\_

Address of Employer \_\_\_\_\_

*Street City State Zip*

Name of Insurance Co. \_\_\_\_\_ Group# \_\_\_\_\_

Address of Insurance Co. \_\_\_\_\_

*Street City State Zip*

### ***Patient Payment Method (required)***

**Cash**       **Check**       **Credit Card #** \_\_\_\_\_ **Exp** \_\_\_\_\_

## Dental History

Why have you come to the dentist today? \_\_\_\_\_

Are you currently in pain? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you require antibiotics before dental treatment? Yes \_\_\_\_\_ No \_\_\_\_\_

Your current dental health is: Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

Do you floss daily? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you brush daily? Yes \_\_\_\_\_ No \_\_\_\_\_

Type of toothbrush? Manual \_\_\_\_\_ Battery \_\_\_\_\_ Electric \_\_\_\_\_

Do your gums ever bleed? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever had periodontal disease? Yes \_\_\_\_\_ No \_\_\_\_\_

Are your teeth sensitive to heat, cold, or anything else? \_\_\_\_\_

Do you have any loose teeth? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever had any serious complications with prior dental treatment?  
Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what? \_\_\_\_\_

Have you had any head, neck, or jaw injuries? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have frequent headaches? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you clench or grind your teeth? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you had any orthodontic work? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever whitened your teeth? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what type of product? \_\_\_\_\_

## Medical History

Patient's Physician Name \_\_\_\_\_ Phone \_\_\_\_\_

**Preferred Pharmacy** \_\_\_\_\_

Are you currently under medical treatment? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain \_\_\_\_\_

Are you currently taking any medications? Yes \_\_\_\_\_ No \_\_\_\_\_

Please list all prescriptions and non-prescription medications you are on now. \_\_\_\_\_

Do you use tobacco? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you use controlled substances? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you wear contact lenses? Yes \_\_\_\_\_ No \_\_\_\_\_

**If Female:** Are you pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_

Nursing? Yes \_\_\_\_\_ No \_\_\_\_\_

Taking oral contraceptives? Yes \_\_\_\_\_ No \_\_\_\_\_

## Medical History Continued

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Diabetes	Y N Kidney Problems
Y N Alcohol Abuse	Y N Difficulty Breathing	Y N Liver Disease
Y N Drug Abuse	Y N Emphysema	Y N Mitral Valve Prolapse
Y N Anemia	Y N Epilepsy/Seizures	Y N Pacemaker
Y N Arthritis	Y N Ever Hospitalized	Y N Psychiatric Problems
Y N Artificial Bones	Y N Glaucoma	Y N Rheumatic Fever
Y N Artificial Valves	Y N Heart Attack	Y N Sinus Problems
Y N Asthma	Y N Heart Murmur	Y N Steroid Therapy
Y N Blood Transfusion	Y N Heart Surgery	Y N Stroke
Y N Cancer	Y N Hepatitis	Y N Thyroid Problems
Y N Chemotherapy	Y N Herpes	Y N Tuberculosis (TB)
Y N Radiation Treatment	Y N High Blood Pressure	Y N Ulcers
Y N Congenital Heart Defects	Y N HIV+/AIDS	Y N Venereal Disease

Are you allergic to any of the following?

Erythromycin	Dental Anesthetics	Tetracycline	Barbiturates	Aspirin	Codeine
Metals	Sulfa Drugs	Penicillin	Latex	Sedatives	Jewelry
Other _____					

### ***Women Only:***

**If you are 40 years of age or older, please complete these questions.**

1. Have you received or are you receiving medication known as bisphosphonates?  
(for example: Aredia, Zometa, Fosamax, Actonel, Boniva, Didronel, & Skelid) Y N
2. Are you taking now or have you taken Fosamax or Actonel?  
(generic names: Fosamax (Alexendronate Sodium) and Actonel ( Risedronate Sodium)  
Y N
3. Have you noticed any changes in your mouth or jaws? Y N
4. Have you had any jaw pain or tooth aches? Y N
5. Have you noticed any foul smell, swelling, or discharge in your mouth? Y N

- Zometra and Aredia are manufactured by Novartis Pharmaceutical, N. J.

## Dental Information

Do you like the appearance of your teeth? Y    N  
 Are you having any areas of concern? Y    N  
 Do you have any old fillings or dental treatment that you are unhappy with? Y    N  
 Is there anything about your smile you do not like? Y    N  
 Would you like your teeth to be whiter? Y    N

How healthy do you want us to get your mouth?  
       \_\_\_\_\_ Don't really care        \_\_\_\_\_ Average        \_\_\_\_\_ The best it can be

Should you need treatment, at what point should we address it?

\_\_\_\_\_ When my tooth hurts or breaks.  
 \_\_\_\_\_ When something is worsening.  
 \_\_\_\_\_ When something isn't ideal.

What quality of dentistry do you want us to recommend?

\_\_\_\_\_ Just patch it        \_\_\_\_\_ Average        \_\_\_\_\_ Ideal/The best

We have the ability to look at your mouth from 3 different perspectives. What combination of these would you like us to use for you?

\_\_\_\_\_ As a **general** dentist    \_\_\_\_\_ As a **cosmetic** dentist    \_\_\_\_\_ As a **functional** dentist

Has fear ever been an issue for you in a dental office? Y    N  
 Has time ever been a factor in getting your dental work done? Y    N  
 Has the cost of dental treatment been a concern for you? Y    N

What can we do to help you with this? \_\_\_\_\_  
 \_\_\_\_\_

## Authorization (signature required below)

**I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I understand that I am responsible for payment of services rendered. As a courtesy, we will file your dental insurance as an out of network provider, so you may receive a reimbursement. I have received a copy of this office's Notice of Privacy Practices.**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

*Office use only*

### Medical History Updates

*Office use only*

I have read my medical history dated \_\_\_\_\_ and confirm that it states past and present medical conditions.

\_\_\_\_\_ (signature and date)

I have read my medical history dated \_\_\_\_\_ and confirm that it states past and present medical conditions.

\_\_\_\_\_ (signature and date)

I have read my medical history dated \_\_\_\_\_ and confirm that it states past and present medical conditions.

\_\_\_\_\_ (signature and date)