



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

Name _____ Birthdate _____ SS# _____
Check appropriate box: Minor Single Married Divorced Widowed
Address _____ City _____ State _____ Zip _____
Home phone _____ Mobile phone _____ E-mail address _____
How do you prefer to be reminded of your appointments?
Check appropriate box: Home Work Cell E-mail Text
Full-time Student: Yes No If Yes, name of school/college _____
Address _____ City _____ State _____ Zip _____
Employer _____ Work phone _____ x _____
Whom may we thank for referring you? _____
Person to contact in case of an emergency _____ Phone _____
Address _____ City _____ State _____ Zip _____
Closest relative not living with you _____ Phone _____
Address _____ City _____ State _____ Zip _____

Responsible Party (If Patient is a child)

Name _____ Birthdate _____ SS# _____
Address _____ City _____ State _____ Zip _____
Home phone _____ Mobile phone _____ E-mail address _____
Employer Name _____ Work Phone _____ x _____
Employer address _____ City _____ State _____ Zip _____
Payment is expected as services are rendered unless prior financial arrangements have been made. For your convenience, we offer the following methods of payment: Cash, Personal Check, Visa, Master Card, Discover, or ask us about interest free credit which may be obtained through Care Credit for balances over \$300.

Primary Dental Insurance

Name of insured _____ Relationship to patient _____
Birthdate _____ SS#/ID# _____ Group number _____
Employer _____
Insurance company _____ Phone number _____
Address _____ City _____ State _____ Zip _____

If you have additional dental insurance, complete the following:

Name of insured _____ Relationship to patient _____
Birthdate _____ SS#/ID# _____ Group number _____
Employer _____
Insurance company _____ Phone number _____
Address _____ City _____ State _____ Zip _____

Patient Medical Information

Physician _____

Office Number _____

Are you under medical treatment now?

Yes No

Do you have any allergies to medications,

Yes No

If yes, please list:

Latex, metals, iodine?
 If yes, please list:

Are you taking any medication for osteoporosis?
 If yes, please list:

Are taking a blood thinning medication?
 If yes, please list:

Women only:

Are you pregnant?

If yes, what month _____

Are you nursing?

Are you taking oral contraceptives?

Are you taking any other medications at this time?
 If yes, please list:

Do you have or have you had any of the following:

	Yes	No		Yes	No		Yes	No
Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease or Attack	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis / Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	A.I.D.S.	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever / Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints / Valves	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Fainting / Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>						

Patient Dental Information

	Yes	No		Yes	No
Date of last dental exam _____			Do you have frequent headaches?		<input type="checkbox"/>
<input type="checkbox"/>			Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>	Do you bite your lips or cheek frequently?		<input type="checkbox"/>
Are your teeth sensitive to hot or cold?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had orthodontic treatment (braces)?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to sweet or sour liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	Do you like your smile?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel pain in any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Would you be interested in hearing about the variety of options available for improving the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>			
Have you had any neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>			
Have you experienced any of the following problems in jaw:	<input type="checkbox"/>	<input type="checkbox"/>			
Clicking	<input type="checkbox"/>	<input type="checkbox"/>			
Pain (joint, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>			
Difficulty in opening and closing	<input type="checkbox"/>	<input type="checkbox"/>			
Difficulty in chewing	<input type="checkbox"/>	<input type="checkbox"/>			

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. The undersigned hereby authorizes Doctor and staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic embodies a certain risk. I authorize Doctor 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 authorize my insurance company to pay all dental benefits to the doctor. I understand that my dental insurance carrier may pay less than the actual bill for services and I agree to be responsible for payment of all services rendered on my behalf or my dependents. I further understand that a finance charge of 1.5% per month (18% APR) may be added to any balance over 60 days. I promise to pay collection costs and reasonable attorney fees as may be required to effect collection of this note.

Signature _____

Date _____