PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health.

Patient's First name: ______________________ Last name: ______________________

Preferred name: ______________________ Date of birth: ______________________

If minor, parents/guardian names: ______________________

Gender: ❑ Male ❑ Female Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Address: ______________________ City: __________ State: ______ Zip: ______

Home phone: ______________ Cell phone: ______________ Work phone: ______________

Email address: ______________________ Driver License #: ______________________

Employer: ______________________ Occupation: ______________________

Whom may we thank for referring you to our office? ❑ Friend ❑ Flyer ❑ Office Sign ❑ Radio ❑ Internet ❑ Other:

____

Names and relationships of other family members who are patients of our practice:

____

BILLING, CREDIT, AND INSURANCE INFORMATION:

❑ **Not covered by dental insurance**

Primary Insurance:

Policy Holder's First name:______________________ Last name: ______________________

Date of birth: ______________________ Social Security number: ______________________

Dental Insurance Co: ______________________ Group number: ______________________

Employer: ______________________

Address: ______________________ City: __________ State: ______ Zip: ______

Secondary Insurance:

Policy Holder's First name:______________________ Last name: ______________________

Date of birth: ______________________ Social Security number: ______________________

Dental Insurance Co: ______________________ Group number: ______________________

Employer: ______________________

Address: ______________________ City: __________ State: ______ Zip: ______

DENTAL HISTORY

Reason for visit/main concern?

- ❑ Check-up
- ❑ Cleaning
- ❑ Toothache

Date of last dental visit:

____

Previous dentist name:

____

Previous dentist phone #: ______________________

Previous dentist address:

____

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Pain or discomfort
- ❑ Sensitivity to hot/cold/sweets
- ❑ Difficulty chewing/eating
- ❑ Dry mouth/excessive thirst
- ❑ Loose teeth
- ❑ Food catches between teeth
- ❑ Mouth odors/bad taste
- ❑ Sore, bleeding gums
- ❑ Gag easily
- ❑ Trauma to the mouth/jaw
- ❑ Wear dentures
- ❑ Grind teeth/clench jaws
- ❑ Jaw joint pain/TMJ
- ❑ Nervous about dental treatment
- ❑ Bad dental experience

Any problems with past dental treatment: ______________	

Medical Health History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:____________________________________

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:____________________________________

____

Women:

- ❑ May be pregnant
  Expected delivery date: ____________
- ❑ Taking hormones or contraceptives

Name of your physician: ____

Do you have any disease, condition, or problem not listed above? ____

____

Please add anything else you would like us to know about: ____

____

General Consent to treatment

I agree and consent to a dental examination which may include x-rays, cleaning, and fluoride applications. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of information

I authorize the release of any information regarding my dental/ medical history, diagnosis or treatment to third party payers and/or other health professionals.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to the dental office.

Photography release

I authorize the dental office to take photographs of me for identification and to help me better understand my current dental condition and treatment options.

I understand and will comply with the office appointment policy.
I understand and agree to the general consent to treatment.
I authorize the release of information.
I authorize photographs to be taken of me.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient (or guardian): ________________________________ **Date:** ________________

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