



Welcome to your new dental office. Our commitment is to provide you with personal care utilizing the best possible preventive and cosmetic dental techniques. Please take time to carefully complete the following information.

Date_____

Name_____ Birthdate_____ Home Phone_____

Address_____ City_____ State_____ Zip_____

Sex: M___ F___ Age_____ SS#_____ Marital Status___ E-Mail Address_____

Patient Employed By_____ Occupation_____

Business Address_____ Business Phone_____ Cell Phone_____

Spouse Name_____ Occupation_____

Spouse Birthdate_____ Business Phone_____

In Case of Emergency Contact_____ Phone_____ Relationship_____

Whom May We Thank For Referring You?_____

DENTAL INSURANCE INFORMATION

Name of Insured_____ SS#_____ Birthdate_____

Insured's Employer_____

Dental Insurance Company Name_____

Address (CSZ)_____ Phone_____

Subscriber ID#_____ Group#_____ Policy#_____

Is Patient Covered by *Additional* DENTAL Insurance? YES _____ NO _____

Name of Insured_____ SS#_____ Birthdate_____

Insured's Employer_____

Dental Insurance Company Name_____

Address (CSZ)_____ Phone_____

Subscriber ID#_____ Group#_____ Policy#_____

Physician Name _____ Phone _____

Pharmacy Name _____ Phone _____

Are you under the care of a physician now? _____ If so, what are you being treated for? _____

Ever been hospitalized? _____ If so, when and for what reason? _____

Have you had a serious illness within the last five years? _____ If so, what was it? _____

What prescription or over-the-counter medications are you presently taking (please include herbs and vitamins)

Are you allergic to any medications or anesthetics? _____ If so, what? _____

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

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Seizures | <input type="checkbox"/> Breathing Difficulty |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Gastrointestinal Problems |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Extreme Nervousness | <input type="checkbox"/> Alcohol Dependency |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Drug Dependency |
| <input type="checkbox"/> Tumors | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Cancer (Type _____) | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Muscular Disorder | |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Asthma | |
| <input type="checkbox"/> High Blood Pressure | | <input type="checkbox"/> Sleep Apnea | |

Purpose of today's visit _____

List any previous major dental treatment _____

Date of last dental exam _____ Date of last full mouth x-rays _____ Previous Dentist Name _____

Yes No

- | | | |
|-----|-----|--|
| ___ | ___ | Do you have discomfort with your teeth, jaw or ear? |
| ___ | ___ | Do you have discomfort, sores or lumps in your head or neck? |
| ___ | ___ | Do you clench or grind your teeth? |
| ___ | ___ | Are you confident in your ability to properly clean your teeth? |
| ___ | ___ | Do you floss? How often? _____ |
| ___ | ___ | Have you had a traumatic dental experience? When? _____ |
| ___ | ___ | Are you very nervous about having dental treatment? |
| ___ | ___ | Do you feel you chew efficiently? |
| ___ | ___ | Do you feel you will eventually lose all your teeth, even with proper care? |
| ___ | ___ | Do any members of your family, including parents, wear dentures? |
| ___ | ___ | Are you pleased with the appearance of your teeth? |
| ___ | ___ | Are you interested in saving your teeth? |
| ___ | ___ | Are you concerned about finances needed to return your mouth to health? |
| ___ | ___ | Are you frustrated because you are always having dental work every time you come to the dentist? |
| ___ | ___ | Are you a smoker? How many packs per day? _____ |
| ___ | ___ | Do you ever have fever blisters or mouth sores? How often? _____ |
| ___ | ___ | Have you ever whitened (bleached) your teeth? |

I think my present state of dental health is: _____ excellent _____ good _____ poor

I would like my dental health to be: _____ excellent _____ good _____ poor

If by magic I could change anything about my teeth, it would be: _____

I hereby state that the answers to the questions above are correct to the best of my ability. I furthermore promise to take it upon myself to inform this office of any change in my medical history prior to subsequent dental treatments. I also give my consent for medical and dental professional consultation in regards to my medical or dental history and/or treatment I understand that I am financially responsible for all charges, regardless of any insurance involvement. I agree to pay all collection or legal fees, including interest charges associated with obtaining payment for the outstanding balance.

Signature _____ Date _____