

Primary Insurance and/or Person Responsible for Payment

Name: Mr. Mrs. Ms. _____
 _____ *Last* _____ *MI* _____ *First*

What would you like us to call you? (preferred name): _____

Street Address: _____

City: _____ State: _____ Zipcode: _____

Social Security Number: _____ Birthdate: _____

Employer Name: _____

Employer Address: _____

Occupation _____

Insurance Company: _____

Insurance Phone Number: _____

Group Number: _____ Contract Number: _____

Have you used your insurance this year? yes no

Spouse and/or Secondary Insurance

Name: Mr. Mrs. Ms. _____
 _____ *Last* _____ *MI* _____ *First*

What would you like us to call you? (preferred name): _____

Street Address: _____

City: _____ State: _____ Zipcode: _____

Social Security Number: _____ Birthdate: _____

Employer Name: _____

Employer Address: _____

Occupation _____

Insurance Company: _____

Insurance Phone Number: _____

Group Number: _____ Contract Number: _____

To the best of my knowledge, the information above is correct. I realize that even though this office will provide insurance billing and assist with insurance benefits to the best of their knowledge, all charges for services and collection costs for untimely payments are ultimately my responsibility.

Signature (parent's if minor): X _____ Date: _____

Medical History

Today's Date: _____

Name: Mr. Mrs. Ms. _____ Birthdate: _____
 Last *MI* *First*

Street Address: _____

City: _____ State: _____ Zipcode: _____

Phone# (home): _____ (work): _____

New Dental Insurance? _____

General health: Excellent Good Fair Date of last physical: _____

Physician's name: _____ phone: _____

Are you under current medical treatment? yes no

If yes, please explain: _____

Are you currently taking any medications or herbal supplements? yes no

If yes, please list: _____

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Erythromycin Tetracycline
- Latex Jewelry Metals Dental anesthetics
- Other: _____

Are you on a special diet? yes no

Have you lost or gained more than 10 pounds in the past year? yes no

Do you use any form of tobacco? yes no

What brand? _____ How much? _____ Want to quit? yes no

Women: are you currently Pregnant Nursing On hormone therapy On birth control meds

Has a physician ever informed you that you have or have had any of the following?

- | | |
|--|--|
| Rheumatic fever <input type="checkbox"/> yes <input type="checkbox"/> no | Respiratory disease <input type="checkbox"/> yes <input type="checkbox"/> no |
| Heart murmur <input type="checkbox"/> yes <input type="checkbox"/> no | Intestinal disease <input type="checkbox"/> yes <input type="checkbox"/> no |
| Mitral valve prolapse <input type="checkbox"/> yes <input type="checkbox"/> no | Cancer <input type="checkbox"/> yes <input type="checkbox"/> no |
| Other heart ailment <input type="checkbox"/> yes <input type="checkbox"/> no | Chemo/Radiation therapy <input type="checkbox"/> yes <input type="checkbox"/> no |
| Artificial joints <input type="checkbox"/> yes <input type="checkbox"/> no | Liver disease <input type="checkbox"/> yes <input type="checkbox"/> no |
| HIV/AIDS <input type="checkbox"/> yes <input type="checkbox"/> no | Kidney disease <input type="checkbox"/> yes <input type="checkbox"/> no |
| Hepatitis <input type="checkbox"/> yes <input type="checkbox"/> no | Major operations <input type="checkbox"/> yes <input type="checkbox"/> no |
| Pacemaker <input type="checkbox"/> yes <input type="checkbox"/> no | Diabetes <input type="checkbox"/> yes <input type="checkbox"/> no |
| High blood pressure <input type="checkbox"/> yes <input type="checkbox"/> no | Stroke <input type="checkbox"/> yes <input type="checkbox"/> no |
| Fainting spells <input type="checkbox"/> yes <input type="checkbox"/> no | Psychological/Psychiatric treatment ... <input type="checkbox"/> yes <input type="checkbox"/> no |
| Epilepsy <input type="checkbox"/> yes <input type="checkbox"/> no | Caffeine Dependency <input type="checkbox"/> yes <input type="checkbox"/> no |
| Head injuries <input type="checkbox"/> yes <input type="checkbox"/> no | Drug/Alcohol dependency <input type="checkbox"/> yes <input type="checkbox"/> no |
| Blood disorder <input type="checkbox"/> yes <input type="checkbox"/> no | Organ transplant <input type="checkbox"/> yes <input type="checkbox"/> no |
| Latex sensitivity <input type="checkbox"/> yes <input type="checkbox"/> no | |

For office use only

Changes in medical history or medications: _____

Date _____ Pt initial _____

Changes in medical history or medications: _____

Date _____ Pt initial _____

Dental History

When was your last cleaning and examination? _____ Your last dental X-ray? _____

Who was your previous dentist? _____ Phone: _____

What influenced you to change dentists? _____

What is your immediate dental concern? _____

Please check if you have, or ever had the following:

- | | |
|---|---|
| 1. Unfavorable dental experiences ... <input type="checkbox"/> | 13. Sugar or soda pop habit? <input type="checkbox"/> |
| 2. Dental fears <input type="checkbox"/> | 14. Unpleasant taste or odor in mouth <input type="checkbox"/> |
| 3. Prefer no dental anesthesia <input type="checkbox"/> | 15. Viral infection or cold sores <input type="checkbox"/> |
| 4. Dental anesthesia ineffective <input type="checkbox"/> | 16. Jaw problems (TMJ) <input type="checkbox"/> |
| 5. Dental anesthesia bad reaction <input type="checkbox"/> | 17. Difficulty opening mouth widely <input type="checkbox"/> |
| 6. Orthodontic treatment (braces)
When? _____ <input type="checkbox"/> | 18. Stiff or sore facial muscles <input type="checkbox"/> |
| 7. Periodontal (gum) treatment
When? _____ <input type="checkbox"/> | 19. Awaken aware of teeth or jaws <input type="checkbox"/> |
| 8. Bleeding gums <input type="checkbox"/> | 20. Tension headaches <input type="checkbox"/> |
| 9. Habit of chewing hard substances, like ice,
popcorn kernels, etc. <input type="checkbox"/> | 21. Clench or grind teeth <input type="checkbox"/> |
| 10. Part of your mouth is sensitive to
temperature <input type="checkbox"/> | 22. Jaw clicking or popping <input type="checkbox"/> |
| 11. Lumps or bumps on head or neck <input type="checkbox"/> | 23. How often do you brush? _____ |
| 12. Dry mouth <input type="checkbox"/> | 24. How often do you floss? _____ |
| | 25. Other oral health aids: _____ |
| | 26. Wear any oral appliances? _____ |
| | 27. Wearing any removable teeth? _____ |

How important is it for you to keep the rest of your teeth for the rest of your life? (check one):

Not important 1 2 3 4 5 6 7 8 9 10 Very important

How would you rank your smile? (check one):

Unpleasant 1 2 3 4 5 6 7 8 9 10 Beautiful

Please share with us any goals or ideas you may have regarding your oral health or smile:

To the best of my knowledge, the information above is correct. I realize that even though this office will provide insurance billing and assist with insurance benefits to the best of their knowledge, all charges for services and collection costs for untimely payments are ultimately my responsibility.

Signature (parent's if minor): X _____ Date: _____