THE DENTISTS

1 PATIENT INFORMATION

Birthdate _____ SS# _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Currently in Orthodontia/Braces? _____

Who is your Orthodontist? _____

Why did you select our practice? _____

_____

Whom may we thank for referring you? _____

Is another member of your family/relative a patient in our practice?

_____

2 DENTAL INSURANCE

Insured person's full legal name _____

Relationship to Patient _____

Birthdate _____

SS # _____

Employer Name _____

Insurance Co. _____

Is patient covered by additional insurance? ☐ Yes ☐ No

3 PHONE NUMBERS & CORRESPONDENCE

E-mail _____

Home (_____) _____

Work (_____) _____ Ext _____

Cell (_____) _____

Spouse's Name _____

Spouse's Work (_____) _____

IN CASE OF EMERGENCY, CONTACT
(Specify someone who does not live in your household.)

Name _____

Relationship _____

Home (_____) _____

Work (_____) _____

4 HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Apidex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

	YES	NO		YES	NO		YES	NO
Acid Reflux	☐	☐	Dizziness	☐	☐	Low Blood Pressure	☐	☐
AIDS/HIV	☐	☐	Emphysema	☐	☐	Mitral Valve Prolapse	☐	☐
Anemia	☐	☐	Epilepsy	☐	☐	Nervous Problems	☐	☐
Arthritis, Rheumatism	☐	☐	Previous Gum Disease	☐	☐	Pacemaker	☐	☐
Artificial Heart Valves	☐	☐	Headaches	☐	☐	Radiation Treatment	☐	☐
Artificial Joints	☐	☐	Heart Murmur	☐	☐	Respiratory Disease	☐	☐
Asthma	☐	☐	Heart Disease	☐	☐	Sinus Trouble	☐	☐
Bleeding abnormally, with extractions or surgery	☐	☐	Hepatitis Type _____	☐	☐	Steroid Therapy	☐	☐
			Herpes	☐	☐	Stroke	☐	☐
Cancer	☐	☐	High Blood Pressure	☐	☐	Swollen Neck Glands	☐	☐
Chemotherapy	☐	☐	Jaw Pain	☐	☐	Thyroid Problems	☐	☐
Circulatory Problems	☐	☐	Kidney Disease	☐	☐	Tuberculosis	☐	☐
Diabetes	☐	☐	Liver Disease	☐	☐	Tumor or Growth on head or neck	☐	☐

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due Date _____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Amoxicillan ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Latex ☐ Other _____

_____

5 DENTAL HISTORY

Are your teeth sensitive to:

Heat? ☐ Yes ☐ No

Cold? ☐ Yes ☐ No

Sweets? ☐ Yes ☐ No

Biting Pressure? ☐ Yes ☐ No

Does food constantly get stuck between certain teeth in your mouth? ☐ Yes ☐ No

Do you get frustrated because you always have something to be treated or repaired when you visit a dentist? ☐ Yes ☐ No

If you could change anything about your smile, what would you change? _____

Are you dissatisfied with the way your teeth look? ☐ Yes ☐ No

For example: color, shape, spaces, etc. ☐ Yes ☐ No

Do you have any fillings that show in your front teeth? ☐ Yes ☐ No

If any of your mercury amalgam fillings need replacement, would you prefer to have a more natural, tooth-colored restoration instead? ☐ Yes ☐ No

Have you ever had any teeth removed? ☐ Yes ☐ No

How long have these teeth been missing? _____

Do you have any jaw pain or do you grind your teeth? ☐ Yes ☐ No

Do your gums bleed when brushing or flossing? ☐ Yes ☐ No

Do you ever avoid any part of your mouth when brushing? ☐ Yes ☐ No

Have you been instructed regarding proper home care? ☐ Yes ☐ No

Do you have an unpleasant taste or odor in your mouth? ☐ Yes ☐ No

Do you smoke or use tobacco? ☐ Yes ☐ No

Do you frequently snack between meals, or chew gum? ☐ Yes ☐ No

How often do you brush your teeth? _____

How often do you floss? _____

Do you want to learn to control dental disease and retain your teeth? ☐ Yes ☐ No

Has the fear of discomfort kept you from regular dental visits? ☐ Yes ☐ No

Are you deeply concerned about the finances required to return your mouth to excellent dental health? ☐ Yes ☐ No

When was your last dental appointment? _____

What did you have done? _____

How long since your last thorough examination with full mouth x-rays? _____

What prompted you to seek dental care this time? _____

Why did you leave your last dentist? _____

AUTHORIZATION AND RELEASE: I have read and answered the above questions to the best of my knowledge. This is to certify that I, the undersigned, consent to the performing of the dental care procedures agreed to be necessary or advisable, including the use of local anesthesia as indicated. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the dentist to release any information including the diagnosis and records, including radiographs, of any treatment or examination rendered to me during the period of such dental care to other health or dental care providers. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of patient or parent if minor Date

I am aware of The Dentists Notice of Privacy Practices. ____ *I would like a copy* ____ *I do not want a copy*