PATIENT INFORMATION (CONFIDENTIAL)

SS#/SIN _____

Date _____

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov._____ Zip/P.C. _____

Email _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College _____ City _____ State/Prov._____ Zip/P.C. _____

Patient or Parent/Guardian's Employer _____ Work Phone _____

Occupation _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Birthdate _____ Cell Phone _____

Employer_____ SS#/SIN _____ Work Phone _____

Is this person currently a patient in our office? ☐ Yes ☐ No

INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov._____ Zip/P.C. _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

☐ Same as above

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov._____ Zip/P.C. _____

How much is your deductible? _____ How much have you used? _____ Max annual benefit _____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examinations rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____

Signature of patient (or parent/guardian if minor) Date

OVER

PATIENT MEDICAL HISTORY

Physician _____

Office Phone _____

Date of Last Exam _____

1. Are you under medical treatment now? ☐ Yes ☐ No
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? ☐ Yes ☐ No

If yes, please explain _____

_____

3. Are you taking any medication(s) including non-prescription medicine? ☐ Yes ☐ No If yes what medication(s) are you taking? *We can copy your list* _____

_____

_____

_____

_____

4. Have you ever taken Fen-Phen/Redux? ☐ Yes ☐ No
5. Have you ever taken Fosomax, Boniva, Actonel, Plavix or any cancer medications containing bisphosphonates? ☐ Yes ☐ No
6. Have you taken Viagra, Revatio, Cialis or Levira in the last 24 hours? ☐ Yes ☐ No
7. Do you use tobacco?..... ☐ Yes ☐ No
8. Do you use controlled substances?..... ☐ Yes ☐ No
9. Are you wearing contact lenses?..... ☐ Yes ☐ No
10. Are you allergic to or have you had any reactions to the following?

Penicillin or any other Antibiotics..... ☐ Yes ☐ No
Sulfa Drugs..... ☐ Yes ☐ No
Barbiturates..... ☐ Yes ☐ No
Sedatives..... ☐ Yes ☐ No
Iodine..... ☐ Yes ☐ No
Aspirin..... ☐ Yes ☐ No
Any Metals (e.g. nickel, mercury, etc.)..... ☐ Yes ☐ No
Latex Rubber..... ☐ Yes ☐ No
Adhesive..... ☐ Yes ☐ No
Other (please list)_____ ☐ Yes ☐ No

11. Woman only:

a) Are you pregnant or think you may be pregnant?. ☐ Yes ☐ No
b) Are you nursing?..... ☐ Yes ☐ No
c) Are you taking oral contraceptives?..... ☐ Yes ☐ No

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

High Blood Pressure..... ☐ Yes ☐ No
Low Blood Pressure ..... ☐ Yes ☐ No
Heart Disease..... ☐ Yes ☐ No
Heart Attack..... ☐ Yes ☐ No
Heart Murmur..... ☐ Yes ☐ No
Cardiac Pacemaker ..... ☐ Yes ☐ No
Mitral Valve Prolapse..... ☐ Yes ☐ No
Chest Pains..... ☐ Yes ☐ No
Rheumatic Fever..... ☐ Yes ☐ No
Stroke..... ☐ Yes ☐ No
High Cholesterol..... ☐ Yes ☐ No
Swollen Ankles ..... ☐ Yes ☐ No
Fainting / Seizures..... ☐ Yes ☐ No
Epilepsy / Convulsions..... ☐ Yes ☐ No

Kidney Diseases..... ☐ Yes ☐ No
Diabetes..... ☐ Yes ☐ No
Thyroid Problem..... ☐ Yes ☐ No
AIDS or HIV Infection..... ☐ Yes ☐ No
Sexually Transmitted Disease ..... ☐ Yes ☐ No
Respiratory Problems..... ☐ Yes ☐ No
Emphysema..... ☐ Yes ☐ No
Asthma ..... ☐ Yes ☐ No
Hay Fever / Allergies..... ☐ Yes ☐ No
Tuberculosis..... ☐ Yes ☐ No
Liver Disease..... ☐ Yes ☐ No
Hepatitis / Jaundice..... ☐ Yes ☐ No
Rheumatoid Arthritis..... ☐ Yes ☐ No

Arthritis..... ☐ Yes ☐ No
Anemia..... ☐ Yes ☐ No
Autoimmune Disease..... ☐ Yes ☐ No
Lupus..... ☐ Yes ☐ No
Stomach Troubles / Ulcers.... ☐ Yes ☐ No
GERD (Acid Reflux)..... ☐ Yes ☐ No
Joint Replacement or Implant ☐ Yes ☐ No
Cancer..... ☐ Yes ☐ No
Radiation Therapy..... ☐ Yes ☐ No
Glaucoma..... ☐ Yes ☐ No
Recent Weight Loss..... ☐ Yes ☐ No
Other _____ ☐ Yes ☐ No

PATIENT DENTAL HISTORY

1. Do your gums bleed while brushing or flossing?. ☐ Yes ☐ No
2. Are your teeth sensitive to hot, cold, sweet or sour foods?..... ☐ Yes ☐ No
3. Do you feel pain to any of your teeth?..... ☐ Yes ☐ No
4. Do you have any sores or lumps in or near your mouth?..... ☐ Yes ☐ No
5. Have you had any head, neck or jaw injuries?.... ☐ Yes ☐ No
6. Have you ever experienced any of the following problems in your jaw?

Clicking..... ☐ Yes ☐ No
Pain (joint, ear side of face)..... ☐ Yes ☐ No
Difficulty in opening or closing..... ☐ Yes ☐ No
Difficulty in chewing..... ☐ Yes ☐ No

7. Is your home water fluoridated?..... ☐ Yes ☐ No
8. Do you wear a CPAP..... ☐ Yes ☐ No
9. Do you Snore?..... ☐Yes ☐No
10. Do you clench or grind your eeth?..... ☐Yes ☐No
11. Do you have frequent headaches?..... ☐Yes ☐No
12. Do you clench or grind your teeth?..... ☐Yes ☐No
13. Do you bite your lips or cheeks frequently?..... ☐Yes ☐No
14. Have you ever had any difficult extractions in the past?..... ☐Yes ☐No
15. Have you ever had any prolonged bleeding following extraction?..... ☐Yes ☐No
16. Have you ever had any orthodontic treatment?... ☐Yes ☐No
17. Do you wear dentures or partials?..... ☐Yes ☐No

If yes, date of placement _____

18. Have you ever received oral hygiene instructions regarding the care of your teeth or gums? ☐Yes ☐No
19. Do you like your smile?..... ☐Yes ☐No
20. Date of last dental visit?.....