Welcome

Thank you for selecting our dental heatchcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.



Patient Information (confidential)

Name		Birthday		Home Phone	Home Phone	
SS#/SIN	Date	Patier	nt's SexF	_M		
Address		City		State	Zip	
Email		Cell Phone				
Do you prefer to receive calls at your:Home	WorkCe	II				
Check Appropriate:MinorSingle	MarriedDiv	orced	Widowed	Separated		
If Student, Name of School/College		City		State	Full Time Part Tim	
Patient or Parent/Guardian's Employer		Work Phone	e			
Business Address		City		State	Zip	
Spouse or Parent/Guardian's Name	Employe	f		Work Phone _		
Whom May We Thank for Referring You?						
Person to Contact in Case of Emergency						
Deen encible Deuts						
Responsible Party						
Name of Person Responsible for this Account		Relationship	p to Patient			
Address			Home Phor	ne		
Email						
Driver License #						
Employer	Work Phone			SS#/SIN		
Is this Person Currently a Patient in our Office?	YesNo					
CashPersonal CheckCredit Card Insurance information						
Name of Insured					-l	
Birthdate			ocal #		d	
Name of Employer					Zip	
Address of Employer						
Insurance Company Ins. Co. Address					Zip	
How Much is your Deductible?	How Much Have Vo	,			enefit	
now Much is your Deductible?	How Much have to	u osea :		IVIQX. AHHUGI B	e nem	
DO YOU HAVE ANY ADDITIONAL INSURANCE?	YESNO If yes, o	complete the	e following:			
Name of Insured		Relationship	p to Patient			
Birthdate		SS#/SIN		Date Employe	d	
Name of Employer		Union or Lo	ocal #	Work Phone _		
Address of Employer		City		State	Zip	
Insurance Company		Group #		Policy/ID #		
Ins. Co. Address		City		State	Zip	
How Much is your Deductible?	How Much Have Yo	u Usod2		May Appual B	enefit	

Patient Medical History

Physician	Office Phon	e Date of Last Exam	
	yes no	,	no
1. Are you under medical treatment now?	() (, , ,	()
2. Have you ever been hospitalized for any surgical operation		11. Are you allergic to or have you had any reactions to the following?	
or serious illness within the last 5 years?	, , ,		()
If yes, please explain		Penicillin or any other Antibiotics()	()
_ 		Barbiturates() (()
Are you taking any medication(s)		Sedatives() (()
including non-prescription medicine?	, , ,	• •	()
If yes, what medications are you taking?		• •	()
		Any Metals (e.g. nickel, mercury, etc.)	()
4. Have you ever taken Fen-Phen/Redux	() () Latex Rubber() (()
5. Have you ever taken Fosamax (alendronate), Boniva		Other (please list)	()
(ibandronate), Actonel (risedronate) or any cancer		12. Do you have a persistent cough or throat clearing not	
medications contaning bisposphonates?	() (associated with a known illness (lasting more than 3 weeks)? () (()
6. Have you taken Viagra, Revatio (sildenafil), Cialis (tadalafil)		13.Women Only:	
or Levitra (vardenafil) in the last 24 hours?	() (a.) Are you pregnant or think you may be pregnant? \dots () (()
7. Do you use tobacco?	() () b.) Are you nursing?() (()
8. Do you use controlled substances?	() (c.) Are you taking oral contraceptives?	()
9. Do you have or have you had any of the following?			
yes no		yes no yes	no
High Blood Pressure() () Heart Disea	ase	() () Chest Pains() (()
			()
		() () Stroke() (()
			()
. , . , .		() () Tuberculosis() (()
		() () Radiation Therapy() (()
			()
			()
		() () Recent Weight Loss() (
* * * * *		() () Liver Disease() (()
		nplant() () Heart Trouble() (()
			()
		ease() () Mitral Valve Prolapse() (()
Thyroid Problem() () Stomach Ti	roubles / Ulce	rs () () Other	
Patient Dental History			
		D 1 (1) 15	
Name of Previous Dentist and Location	00	Date of Last Exam	
Do your gums bleed while brushing or flossing?	yes no		no ()
Are your teeth sensitive to hot or cold liquids/floods?		9. Do you clench or grind your teeth?()	()
3. Are your teeth sensitive to sweet or sour liquids/foods?) 10.Do you bite your lips or cheeks frequently?	()
			()
4. Do you feel pain to any of your teeth?	, , ,	11. Have you ever had any difficult extractions in the past?	
5. Do you have any sores or lumps in your or near your mouth?) 12. Have you had any prolonged bleeding following extractions?() (()
6. Have you had any head, neck, or jaw injuries?) 13. Have you had any orthodontic treatment?() (()
7. Have you ever experienced any of the following problems in your services of the following problems in your s	•	14. Do you wear dentures or partials?() (()
Clicking		,	
Pain (joint, ear, side of face)) 15. Have you ever recieved oral hygiene instructions regarding	
Difficulty in opening or closing		, , ,	
Difficulty in chewing	() () 16. Do you like your smile?() (()

Authorization and Release

Payment is due in full at the time of treatment unless prior arrangements have been made.

This office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost of dental treatment. I herby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company. I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.